Nursing Practice Guide

September 2003

Washington State Department of Health
Nursing Care Quality Assurance Commission

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Special acknowledgments to:

Shannon Fitzgerald, RN, MSN, ARNP
Nursing Care Quality Assurance Commission

Jeanne Vincent, RN, MS, CPHQ
Scope of Practice Decision Tree

Chuck Cumiskey, RN, Editor
Nurse Practice Manager
Nursing Care Quality Assurance Commission

Markay Newton, Assistant Editor
Nursing Care Quality Assurance Commission

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Nursing Care Quality Assurance Commission

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Department of Health Mission Statement

"The Department of Health works to protect and improve the health of people in Washington State"

Washington State Department of Health

Health Professions Quality Assurance

Nursing Care Quality Assurance Commission

Mission Statement

The mission of the Nursing Care Quality Assurance Commission is to assure safe/quality nursing care for the people of Washington State. This includes defining the scope and standards of practice, determining necessary qualifications for competency assurance in authorizing individuals the right to practice nursing, and limiting the practice of those individuals found to practice below minimum safe competent levels

The Commission's Strategic Plan 2000–2003

The Nursing Commission has developed its Strategic Plan which supports the principles and mission of the Nursing Commission—protection of the public by ensuring access to safe and effective nurses and nursing care. In developing the Plan, the Nursing Commission evaluated a number of critical issues important to our profession. Key issues identified in the Strategic Plan are prioritized on their potential impact on nursing.

I. **Nursing Shortage**—The shortage of nurses is without question the number one issue impacting our profession. The Nursing Commission plans to work with organizations and stakeholder groups to identify contributing factors and to define strategies to address shortages in nursing staff and nursing faculty.

   Changing scopes of practice and shifting roles for nurses and assistive personnel are an inevitable result of the nursing shortage. The Nursing Commission will develop mechanisms to monitor shifts in nursing practice and to identify criteria to differentiate nursing roles.

   The Nursing Commission plays a key role in course content in schools of nursing. The Commission will convene nursing organizations and other interested parties to participate in discussions with nursing educators regarding entry-level nursing skills, role clarification and delegation for LPNs and RNs.

   The Nursing Commission is responsible for providing evidence of continuing competency of nurses. We will work with other nursing organizations to develop objective mechanisms to measure continuing competency.

II. **Medical Errors and Reporting**—The Nursing Commission will develop strategies to reduce nursing practice medical errors. As an initial step, the Nursing Commission will establish data collection systems to identify common causes of errors, including organizational and individual risk factors. Differentiation is essential between system causes of errors and individual nurse accountability based upon objective criteria. Both voluntary and mandatory reporting of nursing errors is required.

III. **Licensing of Nurses**—Ensuring rapid public access to qualified nurses compels us to evaluate the current method of licensing nurses. Implementing multi-state licensure in Washington State through Mutual Recognition is essential to protecting the public. We will work with the public, nursing and employer organizations and members of the state legislature to prepare for legislative action in 2002.

IV. **Information Systems and Data Collection**—The Nursing Commission requires comprehensive, unduplicated data related to the nursing workforce and to practice outcomes achieved by nurses. We will continue to contribute to and cooperate with the creation of national nursing information systems which enhance decision making.

V. **Public Understanding and Perception**—The Nursing Commission will continue to educate the public, nurses and others on the statutory duties of the Nursing Commission to protect the public. We have speakers available for groups interested in learning more about the work of the Nursing Commission in improving the care provided by nurses.

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Purpose

The purpose of the Nursing Practice Guide is to provide tools to assist nurses in a variety of settings, at all levels, with individual practice decisions and to update the profession with trends in health care regulation.

The guide will be updated yearly.

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Section II Interpretive Statements, Policy Statements, and Declaratory Orders Policy/Procedure

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Department Of Health

Health Professions Quality Assurance
Policy/Procedure

Title:	Interpretive Statements, Policy Statements, and Declaratory Orders	**Number:** A02.03
Reference:	RCW 18.130.065 / RCW 34.05.230 / RCW 18.130.040 / DOH policy, Filing Policy and Interpretive Statements, 19.001	
Target Audience and Priority:	AAG—1 Board/Commission Members—1 Committee Members—1 HPQA Management—1 Policy Office—1 Program Managers—1 Staff Attorney/Legal Staff—2 Priority Key: 1–Mandatory, Critical for job performance; 2–Reference, advisory	
Effective Date:	August 28, 2001	
Supersedes:	A02.01 dated July 24, 1996, A02.02 dated December 18, 1998 and incorporates policy A03.01 titled "Interpretive Statements, Policy Statements, And Declaratory Orders Proposed For Adoption Or Issuance By Secretary Authority Professions" dated July 24, 1996	
Approved:	Signature on file	
	Sue Shoblom, Director, Health Professions Quality Assurance	

Policy Statement:

This policy applies to all members of Boards and Commissions and appropriate DOH staff. The policy establishes procedures for the implementation of RCW 18.130.065, which mandates the secretary of health review and coordinate all proposed interpretive statements, policy statements and declaratory orders. The secretary must also inform the board or commission of the results of the review.

RCW 34.05.240 sets specific timelines and procedures for declaratory orders independent of the secretary review under RCW 18.130.065. A declaratory order must be issued within 90 days of receipt of a petition for a declaratory order. There is a separate procedure section for declaratory orders in this policy.

This policy also establishes procedures for review of all proposed interpretive statements, policy statements and declaratory orders by any secretary authority profession. The secretary must also provide the results of the review.

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This policy establishes procedures for implementation of RCW 34.05.230. RCW 34.05.230 mandates that an agency submit to the Office of the Code Reviser for publication in the state register a statement describing the subject matter of the adopted interpretive or policy statement. A contact person's name must also be submitted. Submission of declaratory orders to the Office of the Code Reviser is not required.

Definitions: (as defined in chapter 34.05 RCW Administrative Procedures Act)

Interpretive statement: means a written expression of the opinion of an agency, entitled an interpretive statement by the agency head or its designee, as to the meaning of a statute or other provision of law, of a court decision, or of an agency order. Interpretive statements include interpretive or practice guidelines and advisory opinions and any other written statement that reflects an interpretation of scope of practice or any other law implemented by the Board, Commission or Secretary program.

Policy statement: means a written description of the current approach of an agency, entitled a policy statement by the agency head or its designee, to implementation of a statute or other provision of law, of a court decision, or of an agency order, including where appropriate the agency's current practice, procedure, or method of action based upon that approach.

Declaratory order: means an order declaring the applicability of the statute, rule, or order in question to the specified circumstances.

Procedures (Interpretive or Policy Statements):

Responsibility	Action
Board/Commission/Secretary Authority Profession	Identifies a proposal to consider adopting a policy or interpretive statement or issuance of a policy or interpretive statement.
Profession Staff	1) Sends an email to all Executive Directors, Program Managers and the HPQA Policy Office upon receipt of either 1) a request for an interpretive or policy statement; or 2) direction from a board or commission to begin working on an issue to develop an interpretive or policy statement. The email should summarize the issue to be looked at and request feedback on whether this issue impacts the professions they staff.
Other Professions' Program Staff	2) Provides feedback to profession staff whether or not their profession may have an overlapping scope of practice issue or potential issue or provides profession staff a time frame when they can provide that information to them.

Responsibility	Action
Profession Staff	3) Identifies other professions impacted by the issue and provides notice of meetings whenever the board/commission or secretary authority profession will 1) be discussing the issue; or 2) special interest groups will be making presentations.
	4) During development meets with the HPQA Policy Office to do a preliminary review of the proposal utilizing the questionnaire (Attachment A) that identifies the secretary's criteria for review. Brings copies of other professions' notifications and any responses received from other professions.
	5) Prior to adoption or issuance completes the questionnaire and provides a copy of the completed questionnaire, a copy of the proposed final version of the policy or interpretive statement and copies of other professions notifications and any responses received from other professions to the HPQA Policy Office.
Policy Office/Secretary	Within 30 days from receipt of the completed questionnaire and proposed final version of the policy or interpretive statement and copies of other professions notifications and any other professions responses, the following will occur:
	6) The HPQA Policy Office will review and provide written comments along with copies of the proposal and completed questionnaire to the secretary or the secretary's designee.
	7) The secretary or the secretary's designee will inform the HPQA Policy Office and the Board or Commission of the results of the review and shall provide any comments or suggestions the secretary deems appropriate.
	8) The HPQA Policy Office will be responsible for tracking outcomes of the secretary or the secretary's designee review of interpretive or policy statements.
	9) The HPQA Policy Office will facilitate continued discussion between the Board, Commission, or program and the secretary or the secretary's designee if it is necessary to clarify any of the issues.

Responsibility	Action
	10) **If the secretary or the secretary's designee has no comments,** the policy or interpretive statement becomes effective on the date of initial adoption by the Board, Commission or program.
	11) **If the secretary or the secretary's designee provides recommendations or suggestions to a Board, Commission, or program,** the proposed final version of the policy or interpretive statement will not become final until the Board, Commission or program considers and acknowledges the secretary's recommendations.
Profession Staff	12) Profession staff are not to issue the final policy or interpretive statement prior to completion of the secretary review and response process.
	13) Within three weeks after finalization by the Board, Commission, or program, program staff will provide to the HPQA Policy Office a copy of the interpretive or policy statement.
	14) **The interpretive or policy statements are to be accompanied by a memorandum** prepared on Department of Health letterhead including the following information in the memorandum: • Title of policy or interpretive statement • Issuing entity (board, commission) • Two or 3 sentence description of the subject matter sufficient to inform a potentially impacted party of the subject and allow them to contact the agency for more information. • Name, address and telephone number of the person in the Department from whom a copy of the interpretive or policy statement may be obtained and who can answer basic questions. • Effective date of the policy or interpretive statement.
Policy Office	15) Submits the memorandum to the DOH Agency Rules Coordinator to file with the Office of the Code Reviser for publication in the state register.

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Responsibility	Action
	16) Prepares a biennial report for the legislature on the number of proposed policies and interpretive statements that were reviewed by the secretary or the secretary's designee and how the secretary or the secretary's designee responded to those reviews.

Procedures (Declaratory Orders):

Responsibility	Action
Board/Commission/ Secretary Authority Profession	Receives a petition for a declaratory order with respect to the applicability to specified circumstances of a rule, order, or statute enforceable by the board, commission or secretary.
	All the procedures listed under the procedures for interpretive or policy statements are applicable to declaratory orders except for #'s 12, 14, 15 and 16. RCW 34.05.240 sets specific timelines and procedures for declaratory orders independent of the secretary review under RCW 18.130.065. A declaratory order must be issued within 90 days of receipt of a petition for a declaratory order.

References

RCW 18.130.065 Rules, policies, and orders—Secretary's role states: "The secretary of health shall review and coordinate all proposed rules, interpretive statements, policy statements, and declaratory orders, as defined in chapter 34.05 RCW, that are proposed for adoption or issuance by any health profession board or commission vested with rule-making authority identified under RCW 18.130.040 (2)(b). The secretary shall review the proposed policy statements and declaratory orders against criteria that include the effect of the proposed rule, statement, or order upon existing health care policies and practice of health professionals. Within thirty days of the receipt of a proposed rule, interpretive statement, policy statement, or declaratory order from the originating board or commission, the secretary shall inform the board or commission of the results of the review, and shall provide any comments or suggestions that the secretary deems appropriate. Emergency rule making is not subject to this review process. The secretary is authorized to adopt rules and procedures for the coordination and review under this section."

RCW 34.05.230 states in part: "…(4) Whenever an agency issues an interpretive or policy statement, it shall submit to the code reviser for publication in the Washington State Register a statement describing the subject matter of the interpretive or policy statement, and listing the person at the agency from whom a copy of the interpretive or policy statement may be obtained."

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Attachment A

Secretary Review of Interpretive Statements, Policy Statements, or Declaratory Orders

Profession: _____

Program Staff Contact: _____ **Phone number:** _____

Name of Interpretive Statement ☐ Policy Statement ☐ or Declaratory Order ☐:
(Please check appropriate box)

_____

_____

Date received by HPQA Policy Office: _____

Date returned to program: _____

Date Proposed Final Version Reviewed by Board/Commission: _____

Decision Process for Boards, Commission, or Secretary regulated Professions:

1. A decision tree (Attachment B) is attached for your use when interpretive statements are requested. Some professions may find the decision tree helpful, and other professions may not. It is not mandatory to use the decision tree. If the decision tree was utilized, was the decision tree useful to the requestor?

   ☐ Yes ☐ No

   Comments: _____

   _____

   _____

If the regulatory entity chooses to issue an Interpretive Statement, Policy or Declaratory Statement:

2. Is the subject being addressed expressly permitted in the profession's laws?

   ☐ Yes ☐ No

   If yes, please cite the RCW or WAC: _____

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3. Does the proposed response appear to reflect at least one of the following standards?

   - National Professional standards of practice
   - Literature and research
   - Facility or agency requirements

   ☐ Yes ☐ No

   If yes, please cite the reference:

4. Does the proposed response appear to:

   a) increase the scope of practice of the profession, or

   ☐ Yes ☐ No

   b) overlap another profession's scope of practice?

   ☐ Yes ☐ No

   If yes to either a) or b) above, please identify how: _____

   _____

   _____

5. Has your program a) researched other professions' practice acts and/or b) spoken with another program to determine whether the response will impact that profession?

   ☐ Yes ☐ No

   If yes, please explain research done or dialogue that occurred (please attach copies of other professions notifications and copies of their responses if any were received: _____

   _____

   _____

   _____

   _____

6. If there was opposition from another profession, please identify the profession and describe the issues that remain unsolved.

   _____

   _____

   _____

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7. Were the individuals and/or organizations, which have a recognized interest in this subject or will be significantly affected by it, notified?

☐ Yes ☐ No

If yes, please indicate who was notified and how: _____

_____

_____

_____

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Attachment B

Department of Health

Health Professions Quality Assurance

Using the Practitioner Scope of Practice Tree

(This narrative and the decision tree may be customized by the regulatory entity to best meet the needs of their practitioners. Some professions may find the decision tree helpful, and other professions may not. It is not mandatory to use the decision tree.)

Interpretive Statements are the mechanism by which questions can be answered regarding scope of practice. They are created in response to practitioners or health care consumers who have questions about how to interpret a particular act (state statute or rule), or how to apply the information in their particular practice situation.

Requests for Interpretive Statements are sometimes preceded by a call to the profession's regulatory office for guidance on a clinical or practice issue. Usually the caller will be referred to the particular practice statute or rule that is applicable, if there is one. Not all tasks or procedures are addressed in the law. Rather, the statutes and rules give a broad, process oriented description of acceptable practice.

The usual approach in answering practice questions when the law is not specific is to first identify the level of licensure. The context of the practice situation is also relevant. The degree of independence in performing the activity, skill, or procedure is considered. Questions are raised such as, has the patient-prescriber relationship been established? Is the practitioner following the prescribed regimen? What level of preparation is necessary in order to perform the skill safely and competently? Are there quality assurance mechanisms in place in order to evaluate the performance of the skill or task? What is the community standard? Is there a current body of knowledge cited in literature?

There may be issues of cross-discipline scope of practice and other regulatory concerns. Therefore the option of requesting an Interpretive Statement is always available. Using the following guidelines and the decision tree may enable a practitioner to understand what is within their own scope of practice.

A. Basic Education/Training:

1. Was the skill/task taught in your educational program?
2. If not included in your basic program, have you since completed a comprehensive training program, which included clinical experience? Has this training been documented in your personnel file?
3. Has the task become routine in literature and practice?
4. Is the task/skill in your hiring agency policy and procedures manual?

5. Does carrying out the duty pass the "reasonable and prudent" standard?
6. Is the action reflective of the consumer's desire and is it authorized by statute?

B. Existing Literature and Research

1. Does information exist related to the standard of care from a local, community or national perspective related to the skill/task?
2. Are there statements or opinions from professional groups or organizations about the skill/task?
3. Does the skill/task meet the requirements of the Washington State practice acts?

If you can answer "yes" to all of the above questions, you many not need an interpretive statement. If you would like to request an Interpretive Statement, you may:

1. Complete an Interpretive Statement Request form and submit evidence of a literature research using the criteria in B above. Other information requested is listed on the form.
2. Send the form and accompanying information to:

Program Name: _____
Address: _____
_____
_____
Program Contact: _____
Phone: _____

It may take some time to develop an Interpretive Statement if one does not already exist on the subject. You will be notified of an approximate time that it will be forthcoming and it will be sent to you as soon as it is approved.

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Department of Health

Health Professions Quality Assurance

Interpretive Statement Request Form

1. Request: (Clearly state the question including the facts of the situation). _____

   _____

   _____

   _____

   _____

2. Profession and Practice Area/Specialty: _____

   _____

   _____

   _____

   _____

3. Information regarding person or organization requesting the Interpretive Statement

   Name: _____

   Title: _____

   Organization: _____

   Address: _____

   Phone: _____

   Fax: _____

   E-mail: _____

4. Provide the following supporting documents:

   a. Rationale supporting the request

   b. Literature review

   c. Standardized procedures

   d. Identification of availability of learning resources

   e. Positive and negative implications of requested practice

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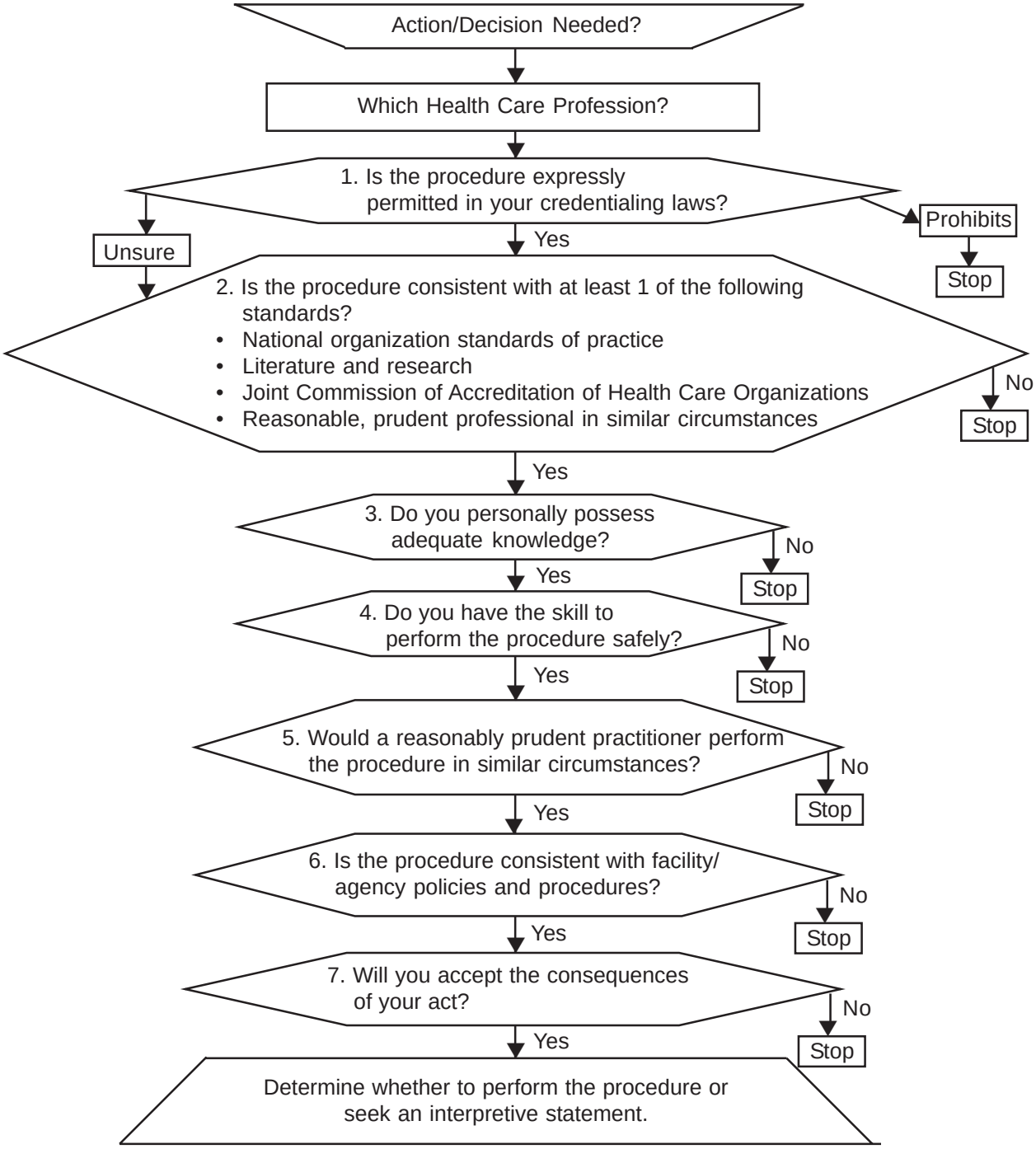
Department of Health

Health Professions Quality Assurance

Practitioner Scope of Practice Decision Tree



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Attachment C

Secretary's Delegation

I, Mary C. Selecky, Secretary of the Department of Health of the State of Washington, do hereby delegate to the Director of the Health Professions Quality Assurance of the Department of Health, the authority of the Secretary of the Department of Health under RCW 18.130.065.

The delegated authority includes review and coordination of all proposed interpretive statements, policy statements, and declaratory orders, as defined in chapter 34.05 RCW, that are proposed for adoption or issuance by any health profession board or commission having rule-making authority under RCW 18.130.040(2)(b).

This delegation includes all other authorities under RCW 18.130.065, whether or not specifically described herein.

This delegation shall remain in effect until revoked or withdrawn by me.

DATED this _____ day of _____.

_____

MARY C. SELECKY, Secretary
Department of Health

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
1300 Quince Street SE • PO Box 47864 • Olympia, Washington 98504-7864

Nursing Care Quality Assurance Commission
Determining Your Scope of Practice

Advisory opinions are the mechanism by which the Nursing Commission can answer questions related to the scope of practice for nursing. Advisory opinions are created in response to nurses and health care providers and/or consumers who have questions about how to interpret the nurse practice act and/or how to apply the nursing process to their particular practice situation. Requests for a formal advisory opinion are sometimes preceded by a call to the nursing commission for guidance on a clinical or practice issue. During the course of describing the clinical/practice situation, the commission will refer to the Law Relating to Nursing RCW 18.79 and the rules (WAC 246-840) which offer additional clarification in applying the law to practice. Often nurses have questions about a particular task or procedure to which they want a definitive yes or no answer. For example, can I as a registered nurse take an order from an office nurse who is working with a physician? The nurse practice act/law for nursing has not specifically delineated tasks and procedures or a "laundry list" of activities that are allowed. Rather, the laws and rules give a broad, process oriented description of acceptable nursing practice. However, there are some common definitions listed in the rules and guidelines that relate directly to the nursing process.

The approach used by the nursing commission in answering practice questions is to first identify the level of licensure. The context of the clinical situation is also relevant. The degree of independence in performing the activity, skill, or procedure is considered. The questions are raised such as, has the patient-prescriber relationship been established? Is the nurse following the prescribed medical regimen? What level of preparation is necessary in order to perform the skill safely and competently? Are there quality assurance mechanisms in place in order to evaluate the performance of the skill or task? What is the community standard? Is there a current body of knowledge cited in the nursing literature?

Over the years, the Nursing Commission has answered many practice questions without a formal advisory opinion. However, there are clinical issues that are more complex than can be answered by trying to apply the nursing process. There may be issues of cross-discipline scope of practice and other regulatory concerns. The option of requesting an advisory opinion is always available. However, there may be existing advisory opinions that are related to the practice issue and it may be useful to review the approach used by the commission in answering similar questions.

The Commission encourages the Washington nurses to empower themselves to determine their own scope of practice. In 1999, the Commission adopted and published a decision tree for determining nursing scope of practice. The Commission will continue to provide guidance and tools to help nurses make well informed decisions about their practice.

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The Nursing Commission is responsible for regulating the practice of nursing in our state. This does not mean that the Commission will decide how nurses will practice in the various practice settings, but whether or not that practice meets the standard of conduct established in the Nurse Practice Act. Using the following guidelines and the attached decision tree, nurses may decide what is within their scope of practice.

A. Basic Nursing Education Preparation

1. Was the skill/task taught in your basic nurse program?
2. If a task has become so routine in the nursing literature and in nursing practice, it can reasonably and prudently be assumed within scope.
3. Is the task/skill in your hiring agency policy and procedure manual?
4. If it was not included in your basic nursing education, have you since completed a comprehensive training program, which included clinical experience. Has this training been documented in your personnel file?
5. Does carrying out the duty pass the “reasonable and prudent” standard for nursing?
6. Is the action reflective of the consumer’s desires and is it appropriately authorized?

If you can answer “yes” to all the above questions, the task is within your scope of practice and you do not need to seek an advisory opinion from the commission. If you cannot answer “yes” to the above, please proceed to option B.

B. Nursing Commission Advisory Opinion

1. Has the Washington State Nursing Commission made an advisory opinion regarding the task/skill?
2. If the task/skill in your hiring agency policy and procedure manual?
3. Is your competency in performing this task documented in your personnel file?
4. Does carrying out the duty pass the “reasonable and prudent” standard for nursing?
5. Is the action reflective of the consumer’s desires and is it appropriately authorized?

If you can answer “yes” to the questions in section B, the task is within your scope of practice and you do not need to seek an advisory opinion from the commission. If you cannot answer “yes” to the above, please proceed to option C.

C. Existing Literature and Research

1. Is this a big, new task you have never done in your facility before?
2. What information exists related to the standard of care from a local, community or national perspective related to the task/skill?
3. Are there statements and opinions from professional groups or nursing organizations about the task/skill?

4. Does the task/skill meet the requirements of the Washington nursing law (nurse practice act)?
5. Does carrying out the duty pass the "reasonable and prudent" standard for nursing?

If you can answer "yes" to these questions, your institution may consider including the task/skill in the policies and procedures, document individual competency and proceed with performance of the task/skill.

If you cannot answer "yes" to the questions in section C above and you would like the nursing commission to consider issuing an advisory opinion, you may:

1. obtain an advisory opinion request from the Commission office
2. do the research using criteria provided by the Commission
3. submit 5 copies of the results of your research for review and consideration by the Nursing Commission's Practice subcommittee. After the committee makes a recommendation, the Commission's conclusion will be relayed to you following the next regularly scheduled Commission meeting.

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Scope of Practice Decision Tree*

*Adopted by permission of the National Council of State Boards of Nursing

1. Describe the act to be performed. Review the scope of practice for your licensure level:

RN assessment, nursing diagnosis, setting goals, planning care strategies, implementing care, delegating care to qualified others, supervising, evaluating, teaching, managing care, maintaining client safety, collaborating with other health care members.

LPN contributing to assessment, participating in development of plan of care, implementing aspects of care as directed, maintaining client safety, participating in evaluating care, and delegating care to qualified others.

ARNP assessing clients, synthesizing and analyzing data, understanding and applying nursing principals at an advanced level; providing expert teaching and guidance; working effectively with clients, families and other member of the health care team; managing clients' physical and psychosocial health-illness status; utilizing research skills; analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem, and selecting appropriate treatment; making independent decisions in solving complex client care problems; performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures; and recognizing limits of knowledge and experience, planning for situations beyond expertise, consulting with or referring to other health care providers as appropriate.

Is the act expressly permitted or prohibited by the Nurse Practice Act for the license you hold?

Unsure	Within Scope for Your License	Prohibited
↓	↓	↓
Go to #2	**Go to # 3**	**STOP**

2. Is the act consistent with at least one of the following standards?

- Nursing Commission standards of practice
- National nursing organization standards of practice
- Nursing literature and research
- Reasonable, prudent nurse in similar circumstances

YES	NO	STOP
↓	→	↓
Go to #3		**Not within the Scope of Practice**

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3. **Do you personally possess the depth and breadth of knowledge to perform the act safely and effectively, as acquired in a pre-licensure program, post-basic program, continuing education program or structured self-study?**

YES → **Go to #4**

NO → **STOP** → **Until Additional Knowledge Gained**

4. **Do you personally possess current clinical skills to perform the act safely?**

YES → **Go to #5**

NO → **STOP** → **Until Clinical Skills Are Attained**

5. **Is the performance of the act within the accepted "standard of care" which would be provided in similar circumstances by reasonable and prudent nurses who have similar training and experience and consistent with appropriately established facility/agency policies and procedures?**

YES → **Go to #6**

NO → **STOP** → **Performance of act may place both patient/client and nurse at risk!**

6. **Are you prepared to accept the consequences of your action?**

YES → **Perform the Act***

NO → **STOP** → **The accountability is not assumed! Notify appropriate person(s).**

*With valid order when necessary, and in accordance with agency policies and procedures

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Nursing Care Quality Assurance Commission

Attached is an Advisory Opinion Request form in response to your inquiry concerning: _____

_____

_____

_____

Please complete and return five (5) copies of all materials:

The following criteria will be used when reviewing the question and in making a recommendation to the Nursing Commission:

1. Safe for the consumer
2. Best interest of the public
3. Safe for the practitioner
4. Part of the nursing process
5. Current trends and national standards
6. Literature review
7. Procedures standardized
8. Mechanisms to maintain competence
9. Impact on Washington
10. Scope of practice affected (ARNP, CRNA, RN, LPN, CNA)
11. Consistent with previous opinions
12. Determination of independent, interdependent or dependent action

Complete and well-documented requests expedite the response time, however, the decision process may take up to six months.

For additional information or questions about the process, please contact the Nursing Commission office at (360) 236-4724 or mailto:markay.newton@doh.wa.gov.

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Advisory Opinion Request Form

1. Opinion request (state clearly the facts involved and the question to which the Commission is requested to reply): _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
2. Practice Area: _____
   _____
   _____
   _____
3. Requesting agency or professional body: _____
   _____
   _____
   _____
4. Name of person in agency or profession body requesting the opinion. Include title, phone number, address and email:_____
   _____
   _____
   _____
5. Provide the following supporting documents:
   a. Rationale supporting the request
   b. Literature review
   c. Standardized procedures
   d. Identification of availability of learning resources
   e. Positive and negative implications of requested practice
   f. Fiscal impact (on industry, nurses, consumers)
   g. Manpower impact (increase/decrease in number of people to provide service)

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Section III
Position Statements

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Washington State Nursing Care Quality Assurance Commission

Position Statement on:

Intravenous Therapy by Licensed Practical Nurses

Licensed Practical Nurses (LPN) may, under the supervision of a registered nurse, administer intravenous medications and fluids provided the LPN has had the appropriate continuing education and practice to prepare to administer these procedures safely and competently.

The LPN may perform administration of fluids, medication, TPN, blood or blood products via central venous catheters and central lines, access these lines for blood draws and administration of emergency cardiac medications via IV push **if** the following occurs:

(1) Strict guidelines and protocols are in place and

(2) The guidelines clearly state all policies and procedures and

(3) Annual review and assessment of the LPN's knowledge, skills and abilities is conducted

(4) Emergency cardiac medications given "IV push" shall be administered by the LPN only if:
a. The LPN has direct supervision per WAC 246-840-010(11)(c) or

b. The LPN has a current ACLS certification,

(5) Blood or blood products shall only be given with direct supervision as per WAC 246-840-010(11)(c).

It is within the scope of LPN practice to perform peripheral venipuncture (to start IV's or draw blood), flush peripheral, PICC and central lines for the purpose of ensuring patency if the following occurs:

(1) The LPN completes an annual instructional program on the initiation of peripheral IV's.

(2) Documentation of satisfactory completion of the instructional program and supervised practice is on file with the employer.

(3) Written policies and procedures are maintained by the employer.

Revised September 12, 2003

Any opinion issued by the Commission is advisory and intended for the guidance of the requesting parties only. The opinion is not legally binding and is not intended to be seen as a declaratory ruling of the Commission, a promulgated regulation or as exempting your facility from any applicable Federal or State requirements.

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Washington State Nursing Care Quality Assurance Commission

Position Statement on:

RNFA: Registered Nurse First Assistant at Surgery

The Registered Nurse (RN) can function in the position of First Surgical Assistant, as long as the nurse stays within the scope of practice of the Registered Nurse license and practices in collaboration with and under the on-site supervision and direction of a surgeon. The RN First Assistant does not concurrently function as a scrub nurse. The RN accepting this responsibility should have documented proficiency in perioperative nursing practice and training in asepsis and infection control, surgical anatomy, physiology, CPR, operative techniques and the recognition of safety hazards. The RN must be able to stabilize the patient if the surgeon becomes incapacitated and then maintain the patient until another physician arrives.

The activities included in first assisting are further refinements of perioperative nursing practice, which are executed within the context of the nursing process. The observable nursing behaviors are based on an extensive body of scientific knowledge. The intraoperative nursing behaviors may include, but are not limited to:

- handling tissue
- providing exposure
- using instruments
- suturing, and
- providing hemostasis.

In all situations, the RN is directly accountable and responsible to the individual consumer for the quality of nursing care rendered.

It is not within the scope of licensed practical nursing to be placed in the role of a first assistant to a surgeon. The first assist nursing role represents a specialized, expanded, scope of practice of the registered nurse, which builds upon the education obtained in the generic nursing program. In addition, a formal education program, which includes both didactic and supervised clinical instruction, is required along with experience in the scrubbing and circulating nurse roles. The licensed practical nurse recognizes and is able to meet the needs of the client in routine nursing situations. A routine nursing situation is one that is relatively free of scientific complexity.

A suggested resource for standards of practice and opportunities to become certified in this role is the Association of Perioperative Registered Nurse (AORN)

AORN
2170 South Parker Road Suite 300
Denver, CO 80231-5711
www.aorn.org/govt

Adopted March 9, 2001

Any opinion issued by the Commission is advisory and intended for the guidance of the requesting parties only. The opinion is not legally binding and is not intended to be seen as a declaratory ruling of the Commission, a promulgated regulation or as exempting your facility from any applicable Federal or State requirements.

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Washington State Department of Health

Washington State Nursing Care Quality Assurance Commission

Position Statement on:

Managing Patients Receiving Epidural Analgesia

It is within the scope of practice of a Registered Nurse to administer medication for the purpose of epidural analgesia if the following requirements, instructions education exceptions are met: Additionally special situations identified under exceptions may also apply.

General Requirements: The institution maintains:

1. Written policy, procedures and Nursing Guidelines for patient monitoring, drug administration and management, which are immediately available for review and implementation.
2. The epidural catheter or port is placed by a licensed anesthesia provider who assumes responsibility for ensuring proper placement and monitors the initial test dose of the medication. A licensed anesthesia provider must be available as defined by institutional policy, to manage any complication, which might arise when the RN is monitoring the epidural analgesia..
3. The registered nurse assumes responsibility for patient care only after the credentialed anesthesia provider who has placed the catheter has verified correct catheter placement, the patient's vital signs are stable and the analgesia level of the patient is established and stabilized.
4. Only registered nurses with the appropriate education, knowledge, skills and supervised clinical practice are allowed to administer and manage the medications for epidural analgesia.
5. With a valid order from an authorized prescriber, the nurse may:
    a. Inject medication into an epidural (after a test dose by an anesthesia provider).
    b. Monitor medication through epidural catheters.
    c. Connect an epidural infusion pump and tubing to an epidural catheter.
    d. Turn the pump on and run an infusion of narcotic analgesia at the rate prescribed by the anesthesia provider.
    e. Increase or decrease infusion rates.
    f. Change a bag of fluid with identical pre-made medication when the prior bag is empty.
    g. Stop the infusion and remove the catheter.

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Education: The Registered Nurse must receive instructions in and demonstrate competence in the following:

1. Epidural anatomy and physiology
2. Indications and contraindications to epidural analgesia
3. Potential adverse reactions
4. Maintenance of the catheter and or infusion device and related equipment
5. Pharmacology and pharmacokinetics of commonly used analgesia medications
6. Nursing care responsibilities as defined and approved by institutional policy.

Exception 1: Monitoring Obstetrical Labor and Delivery patients receiving epidural analgesia via pump infusion (non PCEA)

1. Insertion, initial injection or re-injection of the continuous infusion of epidural catheters for anesthesia or analgesia for the obstetrical patient in labor may ONLY be performed by a credentialed anesthesia provider.
2. The obstetrical nurse may assist in maintaining the continuous epidural infusion by replacing empty infusion syringes or bags with prepackaged solutions. The obstetrical nurse may stop the infusion as needed. The obstetrical nurse may remove the catheter upon direction of the anesthesia care provider.
3. The obstetrical nurse may not adjust the rate of infusion of the continuous epidural infusion and may not administer a bolus dose of medication or adjust the pump to provide a bolus dose.

Exception 2: Monitoring Labor and Delivery patients receiving epidural analgesia via "Parturient Contolled Epidural Analgesia (PCEA)."

The obstetrical nurse may assist in monitoring of Parturient Controlled Analgesia (PCEA), when the following safeguards are in place.

Policy and Procedures to ensure patient safety will be developed by the obstetrical nurse and anesthesia services and approved by the obstetrical service and the institution. These will include at a minimum:

a. Criteria written for patient selection and patient education in the use of the PCEA pump.
b. Only a credentialed anesthesia provider performs the insertion and initial injection of the epidural catheter and will remain present until all vital signs are stable.
c. The anesthesia provider activates and programs the PCEA pump with the proper dosing and lockout procedures.
d. The anesthesia provider attaches the epidural catheter to the PCEA pump.

e. The Anesthesia provider is “readily available” to deal with the complications and institute proper interventions. “Readily available” is defined by institutional policy.

Exception 3: The Position Statement on Managing Patients Receiving Epidural Analgesia does not include the care of patients receiving Intrathecal Analgesia or Intrathecal Infusions for Analgesia.

Exception 4: The Position Statement on Managing Patients Receiving Epidural Analgesia does not include the care of patients receiving epidural anesthesia for palliative reasons, with terminal diagnosis, in whatever setting.

Author: Frank Maziarski, CRNA

Adopted August 2003

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 Quince Street SE • PO Box 47864 • Olympia, Washington 98504-7864

Washington State Nursing Care Quality Assurance Commission Practice Guidelines for Telehealth/Telenursing For Registered Nurses

1. Telephone triage and nursing consultation by telephone or other electronic technology, incorporates unique knowledge, skill and competencies. Nurses employ the full range of the nursing process to gather data, make assessments, and generate plans for care via telephone encounters with patients.
2. Protocols are appropriate tools for implementing treatment plans. A registered nurse may use a protocol that has been written and approved by a physician to initiate a standing order for a medication or treatment. Assuming an appropriate patient-prescriber relationship exists, authorized standing orders may be implemented without consulting an authorized prescriber for a particular patient.

   The registered nurse should implement only standing orders which include a target population, exclusions, the population served, contraindications, special considerations, a specific order, a description of who has the authority to implement the order, physician signature, and review and approval by nursing as well as other involved disciplines.
3. Practice guidelines and protocols for care should be developed based on scientific/empirical evidence and outcomes data or expert opinion. Methods for periodic review of these tools to evaluate care effectiveness and currency of information should be in place.
4. Practice guidelines should evolve through collaboration and professional consensus among all involved health care disciplines.
5. When functions of the nurse involve complex decision making, even when driven by algorithm and protocol, telenursing should be limited to the practice of registered nursing. Licensed practical nursing activities within this context may include information gathering and the provision of patient education.
6. The registered nurse must be able to access a provider licensed to prescribe if questions or issues arise related to the order or the telephone encounter.
7. Documentation of patient encounters must include a record of the patient's statements and symptoms, recommendations for care management with reference to the specific protocol or guideline, timely communication with other health care providers if indicated, and confidentiality of clinical information. Documentation in the patient's permanent record should occur as soon as is reasonably possible.

Telenursing Guidelines adopted by the Nursing Commission November 17, 2000

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Section IV
Policies/Procedures

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Questions of Assignment!!!

Questions by nurses, supervisors, employers, etc., frequently arise regarding delegation of assignments and refusal of assignments.

"Floating" is frequently expressed as an area of concern. Nurses may feel incompetent to fill in on units with which they are unfamiliar (especially critical care units). Sometimes nurses are asked to take more responsibility than they feel competent to handle (i.e. being asked to be in charge of an unfamiliar unit).

Nurses may also feel that their assignment is "too heavy" and may be required to work overtime or double shifts when they feel mentally and/or physically fatigued. They may be asked to do a specific task or procedure that they do not feel qualified to perform or that they believe is beyond their scope of practice.

The situations that arise are many and varied. There are no clear-cut answers or solutions and the majority of these types of situations should be resolved through cooperative efforts of the parties involved at the employment setting.

There are, however, laws, rules and regulations of which all nurses should be aware when trying to resolve this type of situation. Unprofessional conduct is grounds for disciplinary action against a nursing license. Some of the grounds that relate specifically to assignments are:

1) Failure to utilize appropriate judgement in administering safe nursing practice including failure to supervise those to whom nursing activities have been delegated.
2) Incompetence, negligence or malpractice which results in injury to a patient or which creates a risk that a patient may be harmed.
3) Performing acts beyond the scope of practice for which the nurse is licensed.
4) Performing nursing techniques or procedures for which the nurse lacks knowledge, experience and education without instruction, supervision and/or consultation.
5) Delegating nursing care, functions, tasks or responsibilities to others who the nurse knows or has reason to know lacks the ability or knowledge to perform or delegating to unlicensed persons those functions or responsibilities which are to be performed only by licensed persons.
6) Leaving a patient care nursing assignment without notifying personnel so that reasonable arrangements for continuation of care can be made when continued nursing care is required by the condition of the patient.

At times, nurses are told by physicians, other nurses or supervisors to "just follow orders and my license will cover you." Nurses may also be threatened with job loss if they do not accept the assignment. The license of one person can never protect another licensee from potential disciplinary action if the licensee violates a law or any of the rules and regulations. Nor can another person's license protect the nurse from potential civil and/or criminal liability.

All registered nurses are accountable to be sure that they do not delegate nursing care, functions, tasks or responsibilities that are contrary to the law or to the detriment of patient safety. On the other hand, the nurse accepting an assignment is accountable to utilize appropriate judgement when accepting an assignment and to utilize technical competence when carrying out nursing care.

Nurses may be told that if they refuse an assignment they may lose their license for abandonment of the patients. Abandonment occurs **only** when the nurse willfully leaves an assignment he or she has accepted without transferring responsibilities to appropriate personnel. The consequences if a disciplinary action is taken against an individual's license range from a letter of reprimand to license revocation, including probation, limitations or a fine. At no time is revocation of one's license an automatic consequence of disciplinary action. Nurses should always utilize appropriate judgement when considering the refusal of an assignment. A possible alternative to refusal would be to accept that part of the assignment that the nurse feels competent to perform and assist with those activities for which the nurse does not feel competent to accept total responsibility and accountability.

From the Nursing Commission Newsletter, Spring 1990.

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Department Of Health

Health Professions Quality Assurance Division
Washington State Nursing Commission
Policy/Procedure

Title:	Photocopying of Licenses	**Number:** B01.01
Reference:		
Contact:	Licensing Manager	
Effective Date:	April 1996	
S**upersedes:**		
Approved:		
	Donna Campbell, Chair Washington State Nursing Care Quality Assurance Commission	

Purpose Statement:

To address concerns of the Nursing Commission regarding photocopying of licenses and the potential for altering the photocopies.

Policy Statement:

Registered and practical nurses should not allow their licenses to be photocopied.

Photocopied licenses should not be accepted as proof of licensure. An original license must be visually inspected for verification of licensure.

Forms may be developed by employers for personnel records on which the person responsible for licensure verification can document information. Significant information to be maintained could include the date of inspection and other relevant information along with a signed statement that the original license has been visually inspected.

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Section V
Advisory Opinions/ Interpretive Statements

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Response To Request For Advisory Opinion

Question: May a registered nurse with a Master's Degree in Nursing, "perform cardiac catheterization", function as a "pseudo" Cardiology Fellow, perform cardiac interventional procedures, (PTCA, Pericardiocentesis, and pacemaker implants), perform physical examinations, (Medical), order laboratory tests, write prescriptions for cardiac medications, develop medical plans of care. The RN is licensed as an RN in the State of Washington. No formal training beyond the Master's Degree."

Requester: Frankie Manning, RN
Chief, Nursing Services
VA Puget Sound Health Care System
Seattle, WA

Requested: January 22, 1998

Request For Additional Information: None

Answer: No, the functions you have described are not within the scope of RN practice. RNs however, may function as a surgical first assistant in some of the operative procedures you have described.

Some of the activities you have identified may be performed by Advanced Registered Nurse Practitioners under RCW 18.79.050 and WAC 246-840-300 and 246-840-400. For example, physical (medical) examinations, ordering laboratory tests and writing prescriptions. Questions regarding ARNP licensure qualifications should be directed to the Nursing Commission (360) 664-4211.

References: None

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Date: May 5, 1999

Response To Request For Advisory Opinion

Question: "What are the requirements for medical person at camps?" (4-H, church, etc.) If it is a nurse, how is her/his license affected?

Requester: Donna Utter, RN **Requested:** February 19, 1999

Request For Additional Information: None

Answer:

1. The Washington State Nursing Commission can only address your question as it applies to licensed nurses practicing within Washington State.
2. For a nurse licensed in the State of Washington the guides to practice are the laws of the State of Washington including the Nurse Practice Act. These apply to a nurse practicing in a camp setting as they do to a nurse practicing in any other setting. A copy of our *The Law Relating to Nursing Care* is enclosed for your reference.
3. The specific questions you asked about camp operations are beyond the purview of our Commission. However, we would refer you to organizations like the ones you mentioned, 4-H, Boy Scout, Girl Scout, and church camping groups, for their medical policies and guidelines for camp operations. There are also several organizations that represent national camp collectives; they are actually trade organizations for camps. They certify camps and provide technical assistance. They certainly would have prototypes of medical policies and guidelines. American Camping Association, 5000 State Rd. 67 N, Martinville, IN 46151-7902, (765) 342-8456; Christian Camping International/USA. P.O. Box 62189, Colorado Springs, Colorado 80962-2189, (719) 260-9400.

   Finally, insurance companies offering coverage for camps would have standards of practice camps would have to meet.

References:

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Date: February 7, 2000

Response To Request For Advisory Opinion

Question: Can a Licensed Practical Nurse perform the following actions?

1. Enter orders for patients as directed, including consult requests and ordering various tasks.
2. Manage chest tubes including changing the PleurEvac, adjustment of suture holding chest tube in place and removal of chest tubes as directed.
3. Pacing wire removal when directed.
4. Suture and staple removal when directed.
5. Enter surgical scheduling information and submit preoperative orders as directed.
6. Performs appropriate diagnostic and therapeutic procedures.
7. Makes pre and postoperative contacts/arrangements.
8. Provides counseling and education to patients and their significant others pre and postoperatively.
9. Manges/coordinates surgical clinics.
10. Provide communication link between patients and providers/team.
11. Coordinate patient care between Cardiology and Cardiac surgery.
12. Act as liaison between surgical team and other facilities.
13. Coordinate discharge follow-ups with Cardiac, Thoracic and other consultant services.
14. Tracking and making x-ray films available.

Requester: Frankie T. Manning
VA Puget Sound Health Care System
1600 S. Columbian Way
Seattle, WA 98108

Requested: July 13, 1999

Request For Additional Information: None

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Answer: This question covers an array of nursing duties, not related to just one level of nurse. It also involves duties beyond the scope of even a traditional RN. LPNs offer a unique level of nursing and patient care and have the ability to efficiently handle many important duties in the clinical and surgical setting.

It is within the scope of LPN practice to receive and process orders or directions from physicians, PA-Cs, ARNPs, and RNs regarding requests for consults, diagnostic tests, suture and staple removal, scheduling surgery and submitting preoperative orders, and securing all pertinent information for the surgery whether it be dictation, x-rays, or lab work.

It is also within the scope of practice for an LPN to provide pre- and postoperative counseling and education to patients according to the protocols of the facility, to provide a communication link between the patient and the provider team, and to coordinate discharge follow-ups with Cardiac, Thoracic, and other consulting services.

Provided the LPN has received proper training, it is within the scope of practice to care for and properly manage a patient with chest tubes. It is not within the scope to remove chest tubes or to re-suture chest tubes. It is also not within the scope of practice for an LPN to remove pacing wires.

The duties of managing and coordinating surgical clinics or acting as a liaison between a surgical team and other facilities requires a higher, more diverse level of education than is covered in a normal 1 year or 2 year LPN curriculum.

References: WAC 246-840-705

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 Quince Street SE • PO Box 47864 • Olympia, Washington 98504-7864

January 31, 1997

Virginia Hilton, RH, Director of Nursing
Tacoma Lutheran Home & Retirement Community
1301 N Highland Parkway
Tacoma, WA 98406

Dear Ms. Hilton:

At their January 31, 1997 meeting, the Washington State Nursing Care Quality Assurance Commission (Nursing Commission), considered your request for an advisory opinion. In response to the question posed, "Can a Licensed Practical Nurse (LPN) pronounce death? Under what circumstances?"

Yes, the Licensed Practical Nurse may pronounce death under the delegating authority of the Registered Nurse (RN). The requirements as outlined in WAC 246-839-830 would apply:

Determination and pronouncement of death

A nurse may determine and pronounce death, but shall not certify death as defined in RCW 70.58.160 unless the nurse is an Advanced Registered Nurse Practitioner (ARNP) certified nurse midwife as defined in WAC 246-839-300.

(1) A nurse midwife may assume responsibility for the determination and pronouncement of death only if there are written policies and procedures relating to the determination and pronouncement of death in the organization with which the nurse is associated as an employee or by contract, provided:

(a) The decedent was under the care of a health care practitioner qualified to certify cause of death; and

(b) The decedent was a patient of the organization with which the nurse is associated; and

(c) There is a "do not resuscitate order" in the patient's record when the decedent was assisted by mechanical life support systems at the time of determination and pronouncement of death.

(2) A nurse who assumes responsibility of the determination and pronouncement of death shall be knowledgeable of the laws and regulations regarding death and human remains which affect the nurse's practice of the responsibility.

(3) A nurse who assumes responsibility for the determination and pronouncement of death shall:

(a) Perform a physical assessment of the patient's condition;

(b) Insure that family and physician and other care givers are notified of the death; and

(c) Document the findings of the assessment and notification in all appropriate records.

Under the Registered Nurse delegation the Licensed Practical Nurse remains responsible for assuring their own competency in the skills to determine death. The facility should include in the LPN personnel file, documentation of the LPN skills assessment or credentialing used for competency assurance. With this documentation, the Registered Nurse can use his/her delegating authority to permit the Licensed Practical Nurse to pronounce death when the Registered Nurse is unavailable.

Any opinion issued by the Commission is advisory and intended for the guidance of the requesting parties only. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or declaratory ruling by the Commission.

Sincerely,

Victoria Fletcher, RN, MSN, ARNP
Commission Chairperson

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Washington State Nursing Care Quality Assurance Commission

Questionnaire For Advisory Opinion On Nursing Practice

The Nursing Care Quality Assurance Commission issues advisory opinions in response to questions about the authority of various categories of nurses and nursing assistants to perform particular tasks. If you represent an agency, institution or business, the Commission will need the opinion of your legal counsel regarding this procedure or practice prior to issuing a response. Please complete this form in order to assist the Commission in its consideration of your question.

Date: *Nov. 12, 1996*

1. **Name of person(s) submitting question:** *Virginia Hilton, RN*

2. **Position:** *Director of Nursing*
3. **Address:** *1301 N. Highland Pkwy, Tacoma, WA 98406*
4. **Telephone Number:** *206 756-7567*
5. **Institution/Employer:** *Tacoma Lutheran Home & Retirement Community*
6. **Address of Institution**: *above*
7. **What is the question that you would like the Commission to consider?** Some examples of questions submitted to the Commission in the past are; “May an RN assist the physician in insertion of PEG tubes?” or “May a Nursing Assistant-Certified perform glucometer testing?”

   Can Licensed Practical Nurses pronounce death under the same circumstances as registered nurses can as worded in the Law Relating to Nursing Care, 18.79 RCW, May ‘95 p. 2 of 246-839-83?.

8. **Are you asking as an individual or representing your facility?**

   Agency.

9. **Which type(s) of nursing personnel would be performing the procedure and what is the preparation to enable them to do the procedure?**

   Licensed practical nurses and registered nurses already do this under our facility policy.

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10. *Briefly* describe the procedure or task. Attach relevant protocol or practice guidelines.

LPN who is in charge assesses and documents the absence of heart beat and respirations in the absence of a registered nurse or physician.

11. Would this procedure be routinely performed or only for special circumstances? Please describe.

In long-term care or skilled nursing facilities only in the absence of a registered nurse on site. Might also occur in home health settings.

12. List the advantages/disadvantages of this practice/procedure.

Ability of agencies to staff without needing 24/day seven day/week RN coverage.

13. What are the opinions or policy of nursing administration at your institution or agency regarding this procedure?

Opinion is that LPNs are probably already doing this.

14. What is the opinion or policy of your agency/institution's Nursing Practice Committee and nursing staff?

Above.

15. Is this particular issue under litigation or is litigation pending?

No

16. How do you or your agency, facility, or institution plan to track the safety and effectiveness of this procedure or practice?

No formalized plans.

Please attach pertinent literature, studies and standards of practice documentation if available. Incomplete questionnaires will be returned.

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VII. Field Trips and Medication Administration

There are many issues to address before district staff should assume the responsibility for administering oral medications on field trips. Section 504 may apply to the participation of a student with a disability on a field trip and to the administration of oral medications to such a student during the field trip. If the student has an existing 504 accommodation plan requiring districts to administer oral medications at school, this plan would apply to field trips as well unless there were medical reasons not to take the student with a disability on the field trip. The district must investigate whether or not staff can safely accept responsibility for the student who has the right to the field trip and who may require medication on the field trip. There are instances when the student should not go on the field trip because of the unstable/fragile nature of his/her condition and/or the nature of and/or the distance from the emergency care that might be required. There may be other solutions to permit the student to attend, such as:

1. Request the parent accompany the student and attend to the student's medical needs.
2. Assign an appropriately trained and licensed school staff person to care for the child on the trip.
3. The student carries his/her medication and self-administers with parent, physician, and school nurse permission unless the student's Section 504 plan specifically states the district staff will administer the medication.

Please note that if the student does not self-administer medication at school, the student will require training and support by parents and district staff before assuming this responsibility on a field trip. The parent, physician, and school nurse must believe the student can safely take the medication and sign the permission form to do so.

If none of these are possible, the school provides a comparable learning experience at school or in a safe location.

All of the requirements of the oral medication statute must be met on the field trip, e.g., staff must be trained and supervised by an RN as is required when giving medication at school. Students normally taking medication at home may need to take medication while on the a field trip extending beyond normal school hours. Parents must be notified well in advance of the field trip.

If parents indicate that medication not routinely given at school will need to be given on the field trip, then the authorization to administer medication must be completed and signed by parent and physician prior to the field trip. The medication will have to be supplied by the parent in the original pharmacy bottle.

The medication will be carried on the field trip by the designated staff person(s) in a fanny pack or locked box with access limited to those giving the medication. The medication should be either in (1) the original pharmacy-labeled contained or (2) the number of doses required during the field trip are put in a properly labeled, sealed plastic bag. In the latter instance, the school nurse and the designated staff person place the medication in the envelope and record and sign a form with the name of the medication, the strength per dosage unit, the quantity, and the date. The envelope should have the following information: (1) name of student; (2) teacher and grade; (3) medication name; (4) dosage of medication to be given and does per unit of medication; (5) time medication is to be given; and (6) a space for the designated and trained staff person to sign his/her name, date, and time the medication was given to the student. The information in No. 6 should be put on a medication log sheet instead of the envelope. Upon returning to school from the field trip, the signed envelope or log sheet and any left over medication is returned to the school nurse, who will transfer the information to the regular school medication log for the student.

The school nurse and staff person should sign and date a log sheet that documents the return of the medication and signed administration log and any problems that might have occurred with the medication on the field trip.

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Washington State Nursing Care Quality Assurance Commission
Practice Committee
September 8, 2000

Request for advisory opinion from the American Lung Association, Seattle Headquarters, Asthma Management in School Settings Committee

Background information: The following questions were generated by a multi-disciplinary committee charged with developing a standard approach to the management of asthma in K-12 schools. The management guidelines are based on national asthma care principles. Individual nursing care plans for students with asthma will be developed according to orders from authorized prescribers, with parental input, based on a philosophy of self-management by the student.

Registered nurses in school settings function under a special provision which allows them to delegate and supervise the administration of oral medications to unlicensed school personnel. The Commission assumes that the registered nurse uses the nursing process to assess the care needed, verify orders, individualize standard guidelines based on the student's needs, and that certain tasks will not be delegated when the registered nurse determines that care is too complex.

May an RN in a school setting delegate to an unlicensed school employee, the following tasks related to the care of children with asthma?

Assist a student using a peak flow meter to determine the need for inhaled medications for asthma:

Yes, if the plan of care includes the used of a peak flow meter to determine whether or not medication is indicated, the unlicensed school employee who has been trained and is supervised by the registered nurse may verify readings on the peak flow meter and assist the student to follow the instructions on the plan of care. The care plan must include information about when a health care provider or the EMS system should be activated.

Mix liquid medications in a nebulizer chamber for administration via oral inhalation:

Yes, if the registered nurse has taught and supervised the assistive personnel to place medication in a nebulizer chamber, and if she has determined this is a safe procedure within an individual plan of care, this activity is part of the process of administration of oral medications.

Assist a student who uses a mask or Aerochamber-style spacer for inhaled medications for asthma—the medication is ordered "by mouth", but the device also covers the nose:

Yes, if the medication is ordered for oral inhalation, it falls within the category of "po" or "by mouth" whether or not the mask or spacer covers the mouth or the mouth and the nose. Medications ordered to be administered intranasally are not included within this category. (reference: telephone communication with Joe Honda, Pharmacy Board Consultant, 8/24/00)

Initiation of an individualized plan to deal with urgent asthma episodes which may include the use of peak flow meters:

Yes, the assistive personnel may assist the student to identify emergent and urgent situations, including the use by the student of peak flow meters so that the student may determine his or her own status, as long as the registered nurse has included these activities in the plan of care. The registered nurse may not delegate nursing assessment or the nursing process (clinical decision making) to an unlicensed individual.

Orders for inhaled medication which provide a varying dose of medication (i.e. 1-2 puffs):

Yes, if such orders are clarified with the authorized prescriber by the registered nurse, this type of medication may be delegated. The registered nurse should contact the authorized prescriber to determine, for instance, under which circumstances one versus two puffs of an asthma medication should be administered.

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1112 SE Quince Street • PO Box 47890

Olympia, Washington 98504-7890

Tel: (360) 236-4010 • FAX (360) 586-7424

TDD Relay Service: 1-800-833-6388

December 20, 20002

Joanna Boatman, R.N., Chair
Nursing Care Quality Assurance Commission
Post Office Box 47864
Olympia, Washington 98504

Donna Dockter, R.Ph., Chair
Board of Pharmacy
Post Office Box 47863
Olympia, Washington 98504

Dear Mrs. Boatman and Dr. Dockter:

I am writing regarding my review of the Nursing Care Quality Assurance Commission (NCQAC) July 2002 advisory opinion on medication organizer devices. Under RCW 18.130.065, the Secretary of Health reviews and makes recommendations on commission intepretive and policy statements. That statute requires that I consider the effect of the proposed statement on existing health care policies and the practice of health professionals. I have considered the advisory opinion, and the position of the Board of Pharmacy (the Board) and NCQAC. I conclude that allowing registered nurses and licensed practical nurses to fill customized patient medication packages is safe and consistent with existing law and practice. People in our state, especially those in community based care settings, are better served when nurses can fill medication organizer devices.

The July 2002 advisory opinion expresses the opinions of the NCQAC that registered nurses and licensed practical nurses may fill “customized patient medication packages (‘Medisets’, medication organizers, etc.)” only if nine specific conditions are met. For examples, the filling of the organizer must be a component of medication administration; the medications must have been dispensed by a pharmacist and removed from a container which has been labeled for the patient by a pharmacist or pharmacy service; and the nurse fills the organizers in consultation with prescribers, pharmacists and other health care providers as needed.

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The July 2002 advisory opinion is a revised version of an advisory opinion issued in 1991 that authorized nurses to fill medication organizers. Based on that 1991 opinion, registered nurses have been filling medication organizers for residents of community based settings such as boarding homes, and as part of home care services.

The current longstanding practice of nurses filling of medication organizers makes it easier for an individual to be responsible for taking their own medications, or makes it easier and safer for an unlicensed individual to assist them with taking their own medications at the appropriate time and in the appropriate dose. According to the Department of Social and Health Services there have been no reports of harm caused by the use of medication organizers filled by nurses in community settings.

The State of Washington has for years pursued a policy of encouraging people to continue to live in their homes or in community settings. Allowing nurses to fill the medication organizers that are essential to people who need help with medication makes a significant contribution to realizing that policy.

I know that the Board and NCQAC share a concern that care be delivered safely, and have identified important components that constitute best practices for filling medisets. Those best practices are reflected in the nine conditions in the advisory opinion. The Board and NCQAC also agree that there is a need for patient choice of residence, flexibility and options to provide help with medications, that cost is a factor in providing care, and that there are additional difficulties of providing medication assistance in rural areas.

Considering the more than ten years of safe and effective filling of medication organizers by nurses in this state and the options that the practice give residents in community based settings, I support the continued role of nurses in filling medication organizers, and the July 2002 NCQAC advisory opinion that authorizes the practice under nine specific conditions.

I appreciate very much the work that NCQAC and the Board have done to identify the issues and concerns and the practices needed to address them. Thank you for your work on this issue, and for your commitment to protecting and improving the health of the people of Washington State.

Sincerely,

(Signature on file)

Mary C. Selecky
Secretary

cc: Paula Meyer, Executive Director, NCQAC
Don Williams, Executive Director, Board of Pharmacy

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Washington State Nursing Care Quality Assurance Commission
July 12, 2002
NOTE: Replaces and supersedes the May 12, 2002 Statement

Position Statement: Medication Organizer Devices In Community Based Long Term Care and Private Homes: Roles for RNs and LPNs

Advisory Opinion: It is the opinion of the Washington State Nursing Care Quality Assurance Commission that registered nurses and licensed practical nurses may fill customized patient medication packages ("Medisets", medication organizers, etc.) under the following conditions:

- the activity of filling the organizer is a component of medication administration (self-administration, self-administration with assistance or medication administration under nurse delegation) and is intended to ensure resident/consumer safety and accuracy. Medication administration is a recognized nursing skill and function.
- RNs and LPNs may not delegate the filling of medication organizers to assistive personnel, including certified nursing assistants.
- Programs and care settings include: boarding homes, adult family homes, home health, certified programs and homes for the developmentally disabled, private homes, and hospice agencies.
- medications being placed into an organizer for the resident/consumer have already been dispensed by a pharmacist and are being removed from a container which has been labeled for the resident/consumer by a pharmacist or pharmacy service
- the registered nurse or licensed practical nurse fills the medication organizer in consultation with prescribers, pharmacists, and other health care providers as needed
- must include a system which allows the resident/consumer, caregivers, and the RN/LPN to readily identify the medications after they are placed in the new organizer system or container
- must include a method to verify the five rights of medication administration for the resident/consumer (right medication, right resident/consumer, right time, right route, right dose)
- A registered nurse or licensed practical nurse may NEVER interpret a prescription for the purposes of dispensing and may NEVER fill a medication organizer with prescribed legend or controlled drugs for or resident/consumer from a container not already labeled for that particular resident.
- It is not within the scope of practice for a licensed practical nurse to independently perform a nursing assessment for the purposes of developing a complete care plan. However, data gathering and execution of the medication order are fully within the LPN scope of practice.

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Position Statement Regarding Medication Organizers: Supporting Documentation and Rationale

Scope of the issue: Filling of medication organizers by registered nurses is occurring widely in a variety of settings. Registered nurses have been involved with this activity for at least 30 years. The Commission, DSHS, and the Board of Pharmacy have no evidence of patterns of error or resident/consumer harm as a result of nurse involvement with medication organizers. Thousands of Washington residents currently live in community based care settings. These consumers/residents need the services of either a pharmacy or a nurse in order to receive medications safely:

- Adult Family Homes: 10,500 beds
- Boarding Homes: 13,000 beds
- DDD Community Certified: 2,800 beds
- Hospice: 8,000 – 10,000/year
- In-home clients: 20,000/year

Background of the Issue, Regulatory Perspective: A 1991 advisory opinion issued by the former Board of Registered Nursing served as the basis for a number of state agency policies and regulation which allowed registered nurses to fill medication organizers ("Medisets") for residents of adult family homes, boarding homes, home health, and home care settings. The original opinion was based, in part, on information gathered in 1990 from the Board of Pharmacy staff, and indicated that as long as the original medication container was readily accessible for verification of the medication and related orders, registered nurses could fill "Medisets".

By 2000, the Nursing Commission had become aware that queries to the Board of Pharmacy from the public and from state agencies charged with delivering care to clients were resulting in confusion for the public: the opinion of the Board of Pharmacy clearly stated that the filling of a medication organizer by anyone other than a pharmacist or a family member is viewed as dispensing, and therefore outside the scope of nursing practice. Because of the disparity in the two opinions, the Nursing Commission archived its 1991 and 1994 advisory opinions on 9/8/2000, in order to further study the issue and to find a way to advise the public.

Current Status of the Issue: In the fall of 2001, the Nursing Commission directed its practice committee to convene a work group, representative of the community based long term care industry, DSHS regulators and program planners, Board of Pharmacy representatives, and nursing organization leaders. The work group was asked to define the issues and recommend a course of action to the Commission. Through a series of workgroup meetings and research, the Commission learned:

- Technology related to the use of medication delivery systems has advanced in the intervening years since the original advisory opinion was written (i.e. "blister packs", customized patient medication packaging systems from specialized pharmacy services)

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- In-home pharmacy services provide a source of convenient, safe delivery systems for consumers/clients across the state.
- Availability of pharmacy services to community based care facilities and homes varies widely, depending on geographic area, costs, ability to pay, and third party payment restrictions.
- For some residents/consumers, “blister packs” present an access problem of their own; the group heard numerous stories of piles of tablets and capsules on tables, opened for consumers with arthritis and physical disabilities by well-meaning neighbors and relatives.
- Consumers/residents often receive medication from multiple physicians and pharmacies; the nurse visiting the home is often able to fully assess the needs.
- Some pharmacies send pharmacy technicians to community based care settings to organize medications, with no on-site supervision by pharmacists; these technicians would not be able to assess the overall client needs as would a nurse in the home.
- Nurses filling medication organizers for clients do so only by removing medication from containers, which have already been labeled and dispensed by pharmacists.

Best Practices: For the safest care possible, with a focus on access to safe, high quality, resident/consumer-centered care, the work group agreed on these principles:

- Clear communication between the interdisciplinary team (resident/consumer, facility operator/owner, provider/prescriber, pharmacist, registered nurse, licensed practical nurse) is essential.
- Needs and safety of the resident/consumer, along with the rights of the resident/consumer to live as independently as desired, must be central to all care delivered.
- Care given should be based on the best evidence for optimal health care outcomes.
- Medication delivery and administration must be based on the “five rights”.
- Medications must always be labeled and identifiable.
- Policies must be consistent in each and every type of community based care setting in which a resident/consumer might live.
- The process for providing the right medications to residents/consumers safely is not the exclusive province of any single agency or profession.
- Assessment of resident/consumer needs must be ongoing and collaborative: physicians, nurses, pharmacists, social workers and facility owner/operators must be involved with assessment and re-assessment, as well as interdisciplinary communication.

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Section VI
ARNP Scope Information

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ARNP Specialty Overview

Note: "Organization" refers to the professional association which develops standards of practice; "Certification" refers to the separate entity responsible for exam development based on professional standards and scopes.

Name of Specialty/ Organization	Certification	General Parameters	Notes
Family Nurse Practitioner (AANP, ANCC)	ANCC, AANP	Primary health care across the lifespan	
Pediatric Nurse Practitioner (NAPNAP, ANCC)	ANCC, NBPNP	Infants, children, and adolescents. Technically this is up to the 22nd birthday, but many PNPs limit practice to age 18 and under.	
Women's Health Care Nurse Practitioner (AWONN)	NCC	Health care to adolescent and adult females as well as treatment of the male partners of female clients for STDs only. advisory statement in 1997	1996: AWHONN changed the scope of practice to allow treatment of common primary care problems. The Commission issued an cautioning WHNPs to stay within their actual training and education because some are educated for GYN care only.
Adult Nurse Practitioner (ANCC, AANP)	ANCC	"Late adolescents" and adults (AANP). ANCC: Over age 18	Several recent questions have arisen about the upper limit of this practice area—the Commission is exploring this with the certifying bodies via the National Council of State Boards of Nursing.
Geriatric Nurse Practitioner (ANCC)	ANCC	Older adults (age 50 and above)	
School Nurse Practitioner (ANCC)	ANCC (recert)	Students enrolled in pre-K through grade 12 in a school setting. Not licensed for primary care practice outside of a school setting.	No longer being offered as a new certification by ANCC or by the national school nurse association; recertification through CE only.
Neonatal Nurse Practitioner (NANN)	National Certification Corporation	Diagnoses and treats neonates and infants in collaboration with neonatologists & other pediatric physicians.	Previous statements indicated patients had to remain in hospital for NNP to care for them: current statement reflects practice in areas such as NICU follow-up clinics.

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Name of Specialty/ Organization	Certification	General Parameters	Notes
Certified Nurse Midwife	ACC	Care of women with a focus on pregnancy, childbirth, postpartum, care of the newborn, family planning and gynecological care of women.	Also includes care of male partners for treatment of STDs.
Certified Registered Nurse Anesthetist	AANA	Development of anesthesia plans; Provision of anesthesia care within the perioperative setting; provision of pre-operative and postoperative pain control.	
Acute Care Nurse Practitioner	ANCC	Independent health care provision for persons who are acutely or critically ill.	Initial scope of practice statement limited care to secondary and tertiary care settings. 1998 revision reflects the patients, not the settings.
Clinical Nurse Specialist in Psych/ Mental Health and/or Psychiatric Nurse Practitioner	ANCC	Mental and emotional needs and disorders—family or adult.	Separate certification processes are now available for nurses who prepared as either clinical nurse specialists who assume primary responsibility for patient care and for psychiatric nurse practitioners whose programs meet criteria established by ANCC.

ANA:
American Nurses Association
American Nurses Publishing
600 Maryland Ave. SW
Suite 100 West
Washington, DC 20024
www.nursingworld.org

AWONN:
Association of Women's Health, Obstetric and Neonatal Nurses
2000 L St. NW, Suite 740
Washington, DC 20036
800 673-8499
www.ahwonn.org

NAPNAP:
National Association of Pediatric Nurse Practitioners
1101 Kings Highway N., Suite 206
Cherry Hill, NJ 08034-1912
856 667-1773
www.napnap.org

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ACNM:	American College of Nurse Midwives 818 Connecticut Avenue NW, Suite 900 Washington, DC 20036 202 728-9860 www.acnm.org
AANA:	American Association of Nurse Anesthetists 222 South Prospect Avenue Park Ridge, IL 60068-4001 847 692-3097 www.aana.org
NCC:	National Certification Corporation Suite 1058 645 North Michigan Avenue Chicago, IL 60611 800 367-5613 www.NCCNET.org
ANCC:	American Nurses Credentialing Center 600 Maryland Avenue SW, Suite 100 West Washington, DC 20024-2571 800 284-2378 www.nursingworld.org
AANP:	American Academy of Nurse Practitioners Capitol Station, PO Box 12926 Austin, TX 78711 512 442-4262 www.aanp.org
NANN:	National Association of Neonatal Nurses 4700 W. Lake Avenue Glenview, IL 60025-1485 800 451-3795 www.NANN.org
NCBPNP:	National Certification Board of Pediatric Nurse Practitioners 800 South Frederick Avenue, Suite 104 Gaithersburg, MD 20877-4150 888 641-2767 www.pnpcert.org

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ARNPs in Washington State: Frequently Asked Questions

Q Is there a formulary or list of drugs which ARNPs must use in order to prescribe medications or treatments?

A No. Each ARNP is accountable for every medication or treatment ordered. Each ARNP must practice within his or her separate speciality and scope of practice; all treatment decisions should be based on assessment of patient data and must be properly documented.

Q What about schedule II-IV medications? How can an ARNP find out whether or not medications fall into these categories?

A ARNPS may prescribe these medications only after obtaining this level of prescriptive authority (see www.doh.wa.gov/nursing). An excellent source for a listing of the medications, along with prescribing information and potential for diversion and misuse is the Drug Enforcement Authority's website: www.deadiversion.usdoj.gov.

Q Can a physician delegate additional functions to an ARNP in order to allow the ARNP to expand her scope of practice? Examples include: (1) a family physician delegating the authority to see children to an adult nurse practitioner, or (2) a women's health nurse practitioner caring for men with problems other than STDs.

A No. Nursing WACs clearly state that the ARNP must practice within the nationally established scope of practice, and the Medical Commission has stated that physicians may not delegate such functions. "The Medical Commission reminds physicians and physician assistants that the delegation of any function, which requires individuals to be licensed to perform, can only be delegated to individuals licensed for the function. It is considered unprofessional conduct to delegate license required functions to unlicensed individuals or to individuals not licensed in the specific profession. RCW 18.130.180(10) Aiding or abetting an unlicensed person to practice when a license is required." Washington State Medical Quality Assurance Commission Journal; Fall, 1996, vol. 2.

Q How can an ARNP determine if a specific procedure or skill is within his or her scope of practice? Examples include: a pediatric NP performing a circumcision or a women's health NP performing colposcopy.

A The Commission is not able to answer individual questions about such functions. Each ARNP is accountable for his or her own actions and should consult with the professional associations, and should always be able to document the education, experience, and competence level required to perform any function. The Commission's scope of practice decision tree may be another resource.

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Q What are the requirements for an ARNP who would like to be recognized in more than one specialty area?

A The ARNP must meet criteria for each specialty separately. If an ARNP were to hold a Washington ARNP license in the PNP speciality as well as the FNP area of speciality, he or she would submit documentation that a **formal educational program in each area** had been completed (see WAC 246-840-305) and that national certification in both specialty areas has been obtained. Some ARNPs may be certified in subspecialty areas; if the educational program criterion has not been met, or if the specialty in question is not recognized by the Commission, ARNP status may not be granted.

At the time of renewal, the ARNP applicant must submit evidence that the requirement listed in WAC 246-840-450 have been met for each specialty area.

In the example listed above, obtaining and maintaining licensure as an ARNP within the family nurse practitioner category is advised, since the scope of practice for the PNP is contained within the FNP area, and the ARNP license as a family nurse practitioner would cover the ARNP's intended area of practice. In such a situation, the ARNP could maintain national certification within the pediatric nurse practitioner area as a voluntary credential.

Q An ARNP is certified as a Family Nurse Practitioner and is working strictly in a specialty area: Pediatric Neurosurgery. In order to keep his/her license and certification current in Family Practice, do I need to do anything special?

Does it matter that he/she never sees adults? Will he/she be able to go back and work with adults some time in the future? If he/she chooses to work with adults, or work in pediatric primary care for that matter, sometime in the future, does he/she need to meet any additional requirements?

A An ARNP may always choose to subspecialize within his or her scope of practice. At any point in his or her career this may change, as jobs and community needs change. An ARNP cannot expand his or her scope to an age range beyond the initial educational preparation (i.e. an adult NP cannot start seeing kids without going back to school to complete the FNP or a PNP program).

Q Regarding the ARNP who chooses to limit his or her practice within a specialty area of practice: When he or she takes continuing education courses, can the content be limited to the subspecialty area, or should courses encompass the entire spectrum of the specialty?

A CE requirements must be for the specialty but do not need to encompass the entire specialty. It is understood that most health professionals develop a clinical interest of some kind, and therefore it would not be practical to maintain currency in every single topic area. This holds true for the ANCC, AANP, ACNM, NCBPNPA, and CRNA certifying organizations.

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Q If an ARNP chooses to stop working for a few years while his or her children are young, can he or she start working again at some point in the future?

A The practice requirement is 250 hours per biennial renewal period. ARNP practice must be in the role of "primary responsibility for patient care", so working as a clinic or staff nurse would not be okay—an ARNP must see patients and be responsible for the clinical decision making. There is no expectation that the ARNP see every single kind of patient—an FNP may be seeing only adults or children or only older patients, depending on the clinical setting. If an ARNP chooses to stop working for a period of a few years, he or she would have to maintain the license by meeting those clinical practice and CE requirements in some way. Some have volunteered in free clinics, and others have set up mini-clerkships with practicing physicians to get their skills back up to speed. See WAC 246-840-365 for specific details about how to return to active ARNP status from an inactive or expired license status.

Q Can an employer or health care institution impose rules which ARNPs must follow in order to prescribe Schedule II-IV medications? Some institutions are saying that ARNPs must meet certain institutional criteria in order to prescribe, which does not seem right, since ARNPs may now legally write these prescriptions.

A The answer is that yes, any institution, public or private, can choose to limit the privileges (in this case, prescribing privileges) of any credentialed health care provider. The Nursing Commission, Medical Commission, and Pharmacy Board of the State of Washington have no jurisdiction or ability to overrule these institutions' policies. The new (2001) rules which allow ARNPs to prescribe these drugs once the joint practice arrangement and DEA certificate are in place apply to the license of the ARNP, and if the institution or the MD/DO want to impose additional requirements or restrictions, that is within their purview. This is the same situation we have when ARNPs are allowed to have admitting privileges as long as there is a "supervising physician" on record. If the hospital's credentialing bylaws indicate these are the policies, the Nursing Commission can do nothing to "overrule" these policies, even though the admission to hospitals is a role function of ARNPs listed in rule. If ARNPs are finding that these types of policies are cumbersome or difficult, they should contact their professional associations or union bargaining groups.

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Job Titles/ License Titles: Can a RN work as an LPN or an LPN as a Nursing Assistant?

Restructuring of health care delivery, and shifts in staffing mixes have led to interesting inquiries to the Boards of Nursing, RN's, LPN's, and employers have frequently consulted with Board staff about an RN "working as an LPN" or LPN "working as a Nursing Assistant." Questions also include other credentialed roles such as Health Care Assistant.

Sometimes licensing titles (RN or LPN) are being used interchangeably with work site job description designations. For example, an RN may call and say, "I have been offered an LPN shift at the nursing home. Can I work as an LPN?" If that RN is not also licensed as an LPN, he or she may not call themselves an LPN, nor sign documents as an LPN. He can certainly assume the job responsibilities of an LPN, and what salary the nurse and employer agree to for compensation is an employer/employee issue not a licensure or titling issue.

The same broad analysis applies to an LPN considering working a position involving Nursing Assistant level responsibilities. Those responsibilities are included in the education, training, and scope of practice of the LPN but the title is restricted to those persons Registered or Certified as Nursing Assistants

The RN remains an RN and the LPN remains an LPN even if working at a given time in a position that does not require that level of licensure. The new Nursing Care Quality Assurance Commission regulates ARNP's, RN's, LPN's, and some components of Nursing Assistant regulation. The Commission does not manage the programs regulating Health Care Assistants or any other credentialed professions/ occupations. For assistance with any questions on requirements in those professions, call the Receptionist for Health Professions at (206) 586-4561. [Editorial comment: This telephone number changed to (360) 236-4700 as of 1/1/2002.] For assistance with any of the information above related to professions the Commission does regulate, please refer to the telephone roster on page 6 of this newsletter.

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Section VII
Complaint Information

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10 Most Common Complaints Received 6/1/2001 To 12/31/2001

Complaint Type	**Number Received**
Drugs / alcohol (including: diversion, use on duty, positive UA, return from WHPS, etc.)	139
Physical and/or verbal abuse	91
Failure to administer medications and/or treatments	61
Poor standard of care / practice below the standard	58
Medication error (wrong med, dose, and/or patient)	50
Practice beyond the scope	41
Failure to assess	37
Failure to document / document properly	32
Failure to supervise / Inappropriate delegation	32
Failure to report (including: pt. fall, change in condition, abuse by other person, etc.)	23

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Quarterly Stats:
Complaints Received Per Nursing Profession

	RN	ARNP	LPN
1st Quarter 2001	78	2	44
2nd Quarter 2001	59	5	53
3rd Quarter 2001	75	7	46
4th Quarter 2001	75	8	40
1st Quarter 2002	77	7	43

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Nursing Complaint Form

Responding to complaints regarding nursing practice is one of the ways in which the Nursing Commission fulfills its mandate to protect the public. The complaint must be in writing. Please complete both pages of this complaint form and mail to:

WA State Nursing Care Quality Assurance Commission
ATTN: Intake
PO Box 47864
Olympia, WA 98504-7864

You may use additional or continuation sheets as needed. You may attach any supporting documentation.

If you need assistance or require additional information about the complaint process, please contact the Complaint Intake Coordinator at telephone number (360) 236-4715; Fax # (360) 236-4738; or email: sheila.guajardo@doh.wa.gov

Please Type or Print

1. **Name of Nurse(s) and License Number,** if known:
   (Please indicate RN or LPN if known)

   A. _____

   B. _____

   C. _____

   D. _____

   E. _____

2. **Name of Facility, Agency, Clinic or Practice:**

   _____

3. **Describe your specific concerns and/or alleged violations of nursing standards or conduct.** Please provide, as possible, specific dates, times, description of the incident or event, and harm to the patient.

   _____

   _____

   _____

   _____

   _____

   _____

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Employers and/or Supervisors please include the following:

Role of the nurse(s) in the incident: _____

Corrective action taken, if any: _____

_____

Describe actual or potential harm to patient: _____

_____

Does this nurse exhibit a pattern of practice errors. _____

_____

Prior disciplinary/counseling actions: _____

_____

Was nurse's employment terminated? _____

4. **Please Note:**

Details of the complaint will be released to the nurse in question.

Your Name: _____

Address: _____

_____

_____

Phone Number: _____

The Nursing Commission appreciates your concern for public safety and your willingness to step forward in this matter.

The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, as defined in RCW 43.72.010, shall remain confidential under provisions of RCW 43.70.075.

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Department of Health

Health Professions Quality Assurance Division

Policy/Procedure

Title:	Unlicensed Practice Cases	**Number: D10.02**
Reference:	RCW 18.130.190	
Contact:	Health Policy and Constituent Relations Office	
Effective Date:	April 20, 1999	
Supersedes:	D10.01 dated January 13, 1993 and September 12, 1995	
Approved:	Signature on File	
	Patricia O. Brown, Acting Director, Health Professions Quality Assurance Division	

Policy

This policy applies to all unlicensed practice complaints received in the Health Professions Quality Assurance Division (HPQAD).

1. Programs Forward All Unlicensed Practice Complaints to the Investigation Services Unit (ISU)
2. Complaints Are Considered Unlicensed Practice When:
   - the respondent does not hold any type of health care provider's credential
   - the respondent has never applied for a health care provider credential
   - the respondent continues practicing after their credential has been revoked
3. Complaints Are Not Considered An Unlicensed Practice Case To Be Forwarded To ISU When:
   - Applicants are practicing prior to receiving a credential and it is within one year of their filing the application. This type of case would be handled by the program's regular methods of handling reports and complaints received against a credentialed person.

NOTE: Program ***will forward*** the following types of applicant cases to ISU for handling:

a) if an applicant had been denied a credential by the program, or

b) if an applicant was practicing prior to receiving a credential and it has been over one year since they filed an application with the program.

- Credentialed respondents are practicing outside the scope of practice of their credential. This type of case is the responsibility of the program in which the respondent is credentialed.
- Credentialed respondents are practicing with an expired credential.

4. ISU Determines Appropriate Action For Unlicensed Practice Complaints
   - ISU is responsible for unlicensed practice complaints from intake of the complaint to the final case disposition.
   - ISU investigators investigate unlicensed practice cases.
   - The ISU Manager is the final decision-maker for these cases.
5. ISU Refers Cases Found To Involve A Credentialed Provider Aiding and Abetting Unlicensed Practice Back To The Program
   - If ISU finds that a case involves a credentialed provider aiding and abetting unlicensed practice, the appropriate program will be notified immediately.
   - Program proceeds with case intake and takes appropriate action against the credentialed provider.
   - ISU continues with the unlicensed practice portion of the case involving the unlicensed individual.
6. Programs Receive Notice of Unlicensed Practice Case Closure and Monthly Statistics

   ISU distributes unlicensed practice case status reports, which includes case closures and statistics to the programs on a monthly basis.

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Section VIII
Board of Pharmacy Information

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MEDICATION ASSISTANCE

Last Update: 12/17/99

WAC SECTIONS

WAC 246-888-010 Purpose. The legislature recognizes that individuals residing in community-based settings or their own homes, may need assistance self-administering their medications, legend drugs and controlled substances, due to physical or mental limitations. The following rules provide guidance to the individual/resident and caregiver on medication assistance and administration.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-010, filed 12/17/99, effective 1/17/00.]

WAC 246-888-020 What is self-administration with assistance and how is it different from independent self-administration or medication administration? Self-administration with assistance means assistance rendered by a nonpractitioner to an individual residing in a community-based setting or his/her own home. It includes reminding or coaching the individual to take their medication, handing the medication container to the individual, opening the medication container, using an enabler, or placing the medication in the hand of the individual/resident. The individual/resident must be able to put the medication into his or her mouth or apply or instill the medication. The individual/resident does not necessarily need to state the name of the medication, intended effects, side effects, or other details, but must be aware that he/she is receiving medications. The individual/resident retains the right to refuse medication. Assistance with the administration of intravenous and injectable medications are specifically excluded. Self-administration with assistance shall occur immediately prior to the ingestion or application of a medication.

Independent self-administration occurs when an individual/resident is independently able to directly apply a legend drug or controlled substance by ingestion, inhalation, injection or other means. In licensed boarding homes, self-administration may include situations in which an individual cannot physically self-administer medications but can accurately direct others per WAC 246-316-300. These regulations do not limit the rights of people with functional disabilities to self direct care according to chapter 74.39 RCW.

If an individual/resident is not able to physically ingest or apply a medication independently or with assistance, then the medication must be administered to the individual/resident by a person legally authorized to do so (e.g., physician, nurse, pharmacist). All laws and regulations applicable to medication administration apply. If an individual/resident cannot safely self-administer medication or self-administer with assistance and/or cannot indicate an awareness that he or she is taking a medication, then the medication must be administered to the individual/resident by a person legally authorized to do so.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-020, filed 12/17/99, effective 1/17/00.]

WAC 246-888-030 How is self-administration with assistance initiated in a community based setting? An individual/resident or his or her representative from a community based setting may request self-administration with assistance. The practitioner consults with the individual or his or her representative and the facility in making the decision. A practitioner considers such factors as the physical and mental limitations of the individual and the setting or environment in which the individual resides, for purposes of determining whether or not the individual can safely self-administer with assistance. Practitioners include: A physician, osteopathic physician, podiatric physician, dentist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, and a pharmacist. Refer to chapter 69.41 RCW for a complete listing of authorized practitioners.

No additional separate assessment or documentation of the needs of the individual/resident are required in order to initiate self-administration with assistance. It is recommended that providers document their decision making process in the health record of the individual or resident health record.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-030, filed 12/17/99, effective 1/17/00.]

WAC 246-888-040 What if there is a change in the individual's situation? If there is a change in the health status of the individual/resident, medications, physical or mental limitations, or environment, the practitioner may need to be re-involved in the process.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-040, filed 12/17/99, effective 1/17/00.]

WAC 246-888-050 What is an enabler? Enablers are physical devices used to facilitate an individual's/resident's self-administration of a medication. Physical devices include, but are not limited to, a medicine cup, glass, cup, spoon, bowl, prefilled syringes, syringes used to measure liquids, specially adapted table surface, straw, piece of cloth or fabric.

An individual's hand may also be an enabler. The practice of "hand-over-hand" administration is not allowed. Medication administration with assistance includes steadying or guiding an individual's hand while he or she applies or instills medications such as ointments, eye, ear and nasal preparations.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-050, filed 12/17/99, effective 1/17/00.]

WAC 246-888-060 How can medications be altered to assist with self-administration? Alteration of a medication for self-administration with assistance includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids. Individuals/residents must be aware that the medication is being altered or added to their food.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-060, filed 12/17/99, effective 1/17/00.]

WAC 246-888-070 Can all medications be altered to facilitate self-administration? A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication. If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the individual's/resident's record.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-070, filed 12/17/99, effective 1/17/00.]

WAC 246-888-080 What other type of assistance can a nonpractitioner provide? A nonpractitioner can transfer a medication from one container to another for the purpose of an individual dose. Examples include: Pouring a liquid medication from the medication container to a calibrated spoon or medication cup.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-080, filed 12/17/99, effective 1/17/00.]

WAC 246-888-090 Is oxygen covered under this rule? Under state law, oxygen is not a medication and is not covered under this rule. While oxygen is not considered a medication under state law, oxygen does require an order/prescription from a practitioner.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-090, filed 12/17/99, effective 1/17/00.]

WAC 246-888-100 If a individual/resident is able to administer his or her own oral medication through a gastrostomy or "g-tube," can a nonpractitioner provide assistance as outlined in these rules? If the prescription is written as an oral medication via "g-tube," and if a practitioner has determined that the medication can be altered, if necessary, for use via "g-tube," the rules as outlined for self-administration with assistance would also apply.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-100, filed 12/17/99, effective 1/17/00.]

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WAC 246-888-110 Are there any other requirements I need to be aware of? You should be familiar with the rules specifically regulating your residential setting. The department of social and health services has adopted rules relating to medication services in boarding homes and adult family homes.

[Statutory Authority: RCW 18.64.005 and 69.41.085. 00-01-123, § 246-888-110, filed 12/17/99, effective 1/17/00.]

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Best Practice Guidelines For Verbal Prescriptions

Goal: Reduce medication errors, increase patient safety, and prevent fraud and diversion by improving the effectiveness of communication among health care providers. The best person to communicate prescription information to a pharmacist would be the prescriber or at his or her direction, a prescriber's employee or a licensed health care provider treating the patient within the scope of their practice.

When calling in a prescription to a pharmacist, the following information should be provided:

Patient Information

- Name, including middle initial (spell last name if unusual)
- Date of birth
- Phone Number

Drug Information

- Drug name
- Dosage
- Strength
- Directions (dose & frequency of administration)
- Route of administration
- Quantity (number)
- Refills, if any
- Notation of purpose, if appropriate
- If generic substitution is permitted

Prescriber Information

- Name (whole name, with identifier, if a common name)
- Name of clinic or practice
- DEA number if appropriate
- Name and role of the caller, if other than practitioner
- Phone number where the pharmacist can check back with the prescriber if there are any questions about the prescription

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Department of Health
Washington State Board of Pharmacy

Controlled Substance Procedures for Practitioners

By
Donald H. Williams
(360) 236-4828

Introduction:

The distribution, prescribing, administering, dispensing and recordkeeping for controlled substances are governed by the Federal and State Controlled Substances Acts and the regulations adopted to implement these laws. The Federal Act is administered by the Drug Enforcement Administration (DEA) and the State Act is administered by the Washington State Board of Pharmacy. Control is based upon having a "closed system" through which these drugs flow. Every person or firm who prescribes or handles these drugs must be registered, in some way, with the DEA and must maintain certain records so that the drugs may be tracked from the raw ingredient to the point of administration or dispensing to the consumer.

Registration:

Pharmacies, wholesalers, drug manufacturers, etc. must be registered both with the DEA and with the Board of Pharmacy. Practitioners may contact the DEA at (206) 553-4040 in Seattle to obtain registration forms and information. The DEA registration number must appear on every controlled substance prescription issued by a practitioner.

Schedules:

The degree of control exercised over controlled substances is dependent upon the potential for abuse and the degree of psychic or physical dependence which may be caused by the drug. The drugs have been placed in five schedules to reflect control necessary. These schedules, with some examples, are as follows:

Schedule I contains drugs which are highly abused and which have no medical use, including: heroin and marijuana. These are illegal drugs which may not be prescribed or dispensed.

Schedule II contains drugs which may be highly abused but for which there is a medical use, including: morphine, codeine, cocaine, oxycodone, amphetamines, secobarbital, etc. These drugs may only be dispensed by a pharmacy pursuant to a written prescription of a practitioner.

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Schedule III contains drugs with lesser potential for abuse, including: codeine combination products (e.g., aspirin with codeine, benzphetamine, nalorphine, dihydrocodeinone combinations, paregoric, anabolic steroids, etc.)

Schedule IV contains other drugs for which control is deemed necessary, including: phenobarbital, chloral hydrate, chlordiazepoxide, diazepam, phentermine, propoxyphene, pentazocine, etc.

Schedule V contains drugs with low potential for abuse, many of which may be sold over the counter without a prescription, including: codeine cough syrups, antidiarrheal preparations, etc.

Prescribing—Administering—Dispensing

In Washington, the following practitioners may prescribe, dispense, or administer controlled substances when properly registered:

Physicians (MD or DO)
Dentists
Podiatrists
Veterinarians
Physician Assistants (When properly delegated by physician supervisor)
Advanced RN Practitioners (Schedule II-V with collaborative agreement with a physician)
Dispensing limited to a 72 hour supply.

Prescribing: A DEA registration is all that is needed in order to prescribe controlled substances. As noted above, written prescriptions are required for Schedule II drugs and these prescriptions may NOT be refilled. A new prescription is required each time these drugs are to be prescribed. In an emergency, a pharmacist may fill a verbal order for an emergency supply of Schedule II drugs. The prescriber must provide a signed prescription to the pharmacy within seven (7) days. If the prescription is not received within the required time, the pharmacist must notify the DEA and action could be taken against the practitioner's DEA registration. Telephone orders may be accepted for drugs in other schedules and these prescriptions may be refilled not more than five times within a six month period. New prescriptions are required whenever either of these limits is exceeded.

All prescriptions for controlled substances must be dated and signed on the day issued and must contain the full name and address of the patient and the name, address, and DEA registration number of the prescriber. Written prescriptions must be typed or in ink and must be manually signed by the prescriber. You may not post-date prescriptions. If you must give a patient more than one prescription for a controlled substance drug at one visit, the same date of issuance must appear on each prescription.

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Washington has a drug product substitution law (RCW 69.41.100) which requires the practitioner to advise the pharmacist regarding substitution. The ONLY acceptable method to do this on written prescriptions is by using prescriptions with two signature lines at the bottom of the form. Under the line at the right side shall be clearly printed the words "DISPENSE AS WRITTEN." Under the line at the left side shall be clearly printed the words "SUBSTITUTION PERMITTED." The prescriber communicates to the pharmacist by signing the appropriate line. For verbal prescriptions, the prescriber must inform the pharmacist if substitution is permitted.

Verbal orders, including refill authorizations, may be communicated to the pharmacist by an employee of the prescriber, however, this many only be done at the specific direction of the practitioner. A prescriber may NOT delegate to a nurse or office assistant the authority to prescribe. This means that such an agent may not tell a pharmacist that it is allright to refill a prescription unless he/she has specific instructions from the prescriber. These instructions could be given directly by the prescriber or could be noted in the patient's chart (e.g., "diazepam 5mg 1 tid No. 60 refill 3 times." Note to staff, this prescription may be refilled an additional 3 times if requested, however, the patient must be seen in the office before any additional refills are authorized.")

Practitioners must secure their prescription blanks to reduce the possibility of the forms being used illegally. Forgeries are a real problem.

Practitioners may NOT prescribe controlled substances for themselves.

Controlled substances may only be prescribed for therapeutic purposes. You may not prescribe a controlled substance to maintain addiction or to detoxify an addict. Care must be taken when treating "drug addicts" for other medical problems. Methadone may be used to treat pain, however, only a narcotic treatment program which is registered with both the FDA and DEA may use methadone for detoxification or maintenance treatment.

Purchasing: A practitioner may NOT use a prescription form to order controlled substances for administration or dispensing. For Schedule II drugs, a special triplicate order form must be used (DEA form 222). Drugs in other schedules may be ordered in whatever manner is required by the seller (e.g., pharmacy, wholesaler, manufacturer, etc.).

Storage: According to DEA, controlled substances must be stored in a "securely locked, substantially constructed cabinet." For the usual quantities of these drugs which might be stored in a practitioner's office, a locked desk, file cabinet with a lock, locked wood or metal cabinets, or a small safe could qualify as secure storage.

Administering: Practitioners may administer controlled substances to their patients in the practitioner's office. Records must be maintained.

Dispensing: In Washington, practitioners are authorized to dispense the drugs which they prescribe. They may NOT delegate this function to a nurse or other staff member. In addition, in a

group practice, one practitioner could not be designated to dispense the drugs for all of the practitioners. This is considered to be the practice of pharmacy and may only be done by a pharmacist. If a practitioner dispenses, he/she needs to be aware of labeling and recordkeeping requirements. The law (RCW 69.41.050) requires that practitioners place at least the following information on the label:

1. Name of prescriber
2. Name of the patient
3. Complete directions for use
4. Name of the drug (either brand name or generic name)
5. Strength of drug per dose
6. Date of dispensing

Note: The name and strength may be omitted if the practitioner determines that the patient should not have this information, however, this is rarely the case anymore.

If the drug is a trial sample and is being distributed in its original package, the practitioner need only add his/her name along with the patient's name.

Note: We note that this law is commonly violated. Practitioners must improve their practices in the area of labeling samples and other drugs that they dispense.

Packaging: Patients should be able to expect the same packaging of drugs from a prescriber as they are able to obtain from a pharmacist. Paper envelopes and boxes are unacceptable containers for drugs. The use of tight, light resistant glass or plastic containers is required to assure the stability and integrity of today's drugs. In addition, the use of Child Resistant Caps (CRC's) should be the rule rather than the exception. There is a direct correlation between the use of CRC's and the reduction in the poisoning of children.

Records:

Practitioners who dispense and/or administer controlled substances must maintain records to account for the receipt and disposition of these drugs. The Dental Disciplinary Board has developed specific rules regarding the format for these records (See WAC 246-816-050; 060; & 070). Other boards have NOT done this. Therefore, other professionals need only to follow DEA rules. Records must be "readily retrievable." Although your patient records should contain detail regarding all drugs prescribed or dispensed, this site would not be considered to be "readily retrievable." A separate log or records should be maintained to show the name of the patient, name, strength and quantity of drug dispensed, the date of dispensing and the name or initials of the person dispensing or administering the drug. This log shall also indicate detail regarding any receipt of controlled substances.

Invoices, official order forms, and receipts for controlled substances must also be maintained. Having a separate file or hi-lighting the controlled substances to differentiate from other drugs makes these records "readily retrievable."

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A complete inventory of all controlled substances must be performed and documented every two years. It must be in writing, dated, and signed by the person taking the inventory. If you have never taken an inventory, it should be performed as soon as possible. Biennial inventories shall be performed on the same day in subsequent years. All controlled substances, including samples, must be counted.

All losses of controlled substances must be reported to the DEA and to the Board of Pharmacy.

Outdated, deteriorated, and unwanted controlled substances must be disposed of in compliance with the law. These drugs may not be discarded or destroyed. Contact the DEA (206) 553-4040 or the Board of Pharmacy for specific forms and instructions.

Of necessity, this summary does not include all of the laws and rules regarding controlled substances. It is suggested that practitioners contact the DEA, the Board of Pharmacy, or their own licensing board to discuss specific issues related to this topic.

Resources:

Drug Enforcement Administration
220 W Mercer, Suite 104
Seattle WA 98119
(206) 553-4040

Department of Health
310 Israel Road SE
Tumwater, WA 98501

Washington State Board of Pharmacy
PO Box 47863
Olympia, WA 98504-7863
(360) 236-4828

- Dental Commission ..... (360) 236-4860
- Medical Commission ..... (360) 236-4800
- Board of Nursing ..... (360) 236-4708
- Board of Podiatric Medicine ..... (360) 236-4944
- Board of Veterinary Governors ..... (360) 236-4875

State Laws:

RCW 69.50 Uniform Controlled Substances Act

RCW 69.41 Legend Drug Act

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Department of Health
Washington State Board of Pharmacy

P.O. Box 47863
Olympia, Washington 98504-7863
(360) 236-4828

Significant Controlled Substance Regulations

I. Records Required for Purchase or Acquisition
   - A. Name, address, and DEA registration number of supplier
   - B. Name, strength, dosage form, and amount of controlled substances received
   - C. Actual date received
   - D. Records must be kept two years
   - E. Records for Schedule II's must be kept separate from III through V
   - F. Permission must be obtained from DEA to keep records in off site location
   - G. The "received" portion of DEA-22 order forms must be completed upon receipt of the drugs.

II. Disposition Records
   - A. Name of patient
   - B. Address of supplier
   - C. Date of dispensing or administration
   - D. Number of units (or volume) dispensed or administered
   - E. Name or initials of person who dispensed or administered the drug
   - F. Similar information required for any other type of disposition
   - G. Options are available for maintaining prescription refill records

III. Inventory Requirements
   - A. Initial inventory must be taken when controlled substances are first dispensed
   - B. Biennial inventory must:
     1. Include all controlled substances on hand on the date of the inventory
     2. Set forth date on which taken
     3. Indicate whether it was taken at the "open" or "close" of business
     4. May be taken on any date which is within two years of the previous biennial inventory date

IV. Records Required When Controlled Substances are Returned
   - A. Name, address, and DEA registration number of supplier
   - B. Name, strength, dosage form, and amount of controlled substances received
   - C. Actual date of distribution (return)

V. Security Requirements
   - A. All controlled substances must be stored in a securely locked, substantially constructed cabinet, however, pharmacies may "dispense" such substances throughout the stock of non-controlled substances

B. Losses must be reported to DEA and the Pharmacy Board on DEA form 106
C. All registrants are prohibited from employing any person, with access to controlled substances, who has been convicted of a felony related to controlled substances

VI. State Licenses Required as a Prerequisite for Issuance of a DEA Registration Certificate to a Firm
A. Pharmacy, and/or
B. Controlled substance wholesaler, and/or
C. Controlled substance manufacturer

VII. Responsibilities of Pharmacies That Supply Controlled Substances to Practitioners for "Office Use"
A. May distribute up to 5% of total purchases without additional authority
B. Distribution of greater than 5% of total purchases:
1. Must register with DEA as a distributor
2. Comply with excess purchase reporting requirements
C. Copy two of DEA order form 222 must be forwarded to the local DEA office
D. Records must be maintained setting forth:
1. Name, address and DEA registration number of purchaser
2. Actual date of delivery
3. Name, strength, dosage form, and amount supplied

VIII. Transfer of Original Prescription Information Between Pharmacies
A. Permissible in schedule III through V for the purpose of refill dispensing on a one time basis. Pharmacies, however, that share a real-time, on-line database may transfer prescriptions as often as the number of refills permitted by law and prescriber authorization.
B. The transfer must be communicated between two pharmacists
C. The transferring pharmacist must:
1. Write "VOID" on the face of the invalidated prescription
2. Record on the reverse of the invalidated prescription the name, address, and DEA registration number of the pharmacy to which transferred as well as the name of the receiving pharmacist
3. Record the date of the transfer and the name of the pharmacist transferring the information
D. The receiving pharmacist must reduce to writing:
1. The word "TRANSFER" on the face of the transferred prescription
2. The date of issuance and the original number of refills authorized on the original prescription
3. Date of original dispensing, the number of valid refills remaining, and the date of last refill
4. Pharmacy name, address, DEA registration number and original prescription number from which the prescription information was transferred, and the name of the transferor pharmacist

IX. Destruction of Controlled Substances
A. Contact DEA or Pharmacy Board

B. DEA may authorize destruction by registrants under certain circumstances
C. Specialized firms registered with DEA may be used

X. References and Resources

A. Code of Federal Regulations (CFR), Part 1300 to end
Drug Enforcement Administration (DEA)
Seattle Division—Diversion Control
George Leveign, Group Supervisor
Telephone: (206) 553-4040

B. Washington State Board of Pharmacy Lawbook
Department of Health
Washington State Board of Pharmacy
Donald H. Williams, Executive Director
Telephone: (360) 236-4828

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Department of Health
Washington Sate Board of Pharmacy
310 Israel Road S.E.
Tumwater, Washington 98501-7863
(360) 236-4828

Significant Prescribing And/Or Dispensing Rules and Regulations

RCW 69.50.301 Rules—Fees. The board may adopt rules and the department may charge reasonable fees, relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances within this state. [1993 c 187 § 15; 1991 c 229 § 9; 1989 1st ex.s. c 9 § 431; 1971 ex.s. c 308 § 69.50.301.]

NOTES: Effective date—Severability—1989 1st ex.s. c 9: See RCW 43.70.910 and 43.70.920.

RCW 69.50.306 Records of registrants. Persons registered, or exempted from registration under RCW 69.50.302(d), to manufacture, distribute, dispense, or administer controlled substances under this chapter shall keep records and maintain inventories in conformance with the record-keeping and inventory requirements of federal law and with any additional rules the state board of pharmacy issues. [1971 ex.s. c 308 § 69.50.306.]

RCW 69.50.308 Prescriptions. (a) A controlled substance may be dispensed only as provided in this section.

(b) Except when dispensed directly by a practitioner authorized to prescribe or administer a controlled substance, other than a pharmacy, to an ultimate user, a substance included in Schedule II may not be dispensed without the written prescription of a practitioner.

(1) Schedule II narcotic substances may be dispensed by a pharmacy pursuant to a facsimile prescription under the following circumstances:

(i) The facsimile prescription is transmitted by a practitioner to the pharmacy; and

(ii) The facsimile prescription is for a patient in a long-term care facility. “Long-term care facility” means nursing homes licensed under chapter 18.51 RCW, boarding homes licensed under chapter 18.20 RCW, and adult family homes licensed under chapter 70.128 RCW; or

(iii) The facsimile prescription is for a patient of a hospice program certified or paid for by medicare under Title XVIII; or

(iv) The facsimile prescription is for a patient of a hospice program licensed by the state; and

(v) The practitioner or the practitioner’s agent notes on the facsimile prescription that the patient is a long-term care or hospice patient.

(2) Injectable Schedule II narcotic substances that are to be compounded for patient use may be dispensed by a pharmacy pursuant to a facsimile prescription if the facsimile prescription is

transmitted by a practitioner to the pharmacy.

(3) Under (1) and (2) of this subsection the facsimile prescription shall serve as the original prescription and shall be maintained as other Schedule II narcotic substances prescriptions.

(c) In emergency situations, as defined by rule of the state board of pharmacy, a substance included in Schedule II may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the pharmacy. Prescriptions shall be retained in conformity with the requirements of RCW 69.50.306. A prescription for a substance included in Schedule II may not be refilled.

(d) Except when dispensed directly by a practitioner authorized to prescribe or administer a controlled substance, other than a pharmacy, to an ultimate user, a substance included in Schedule III or IV, which is a prescription drug as determined under RCW 69.04.560, may not be dispensed without a written or oral prescription of a practitioner. Any oral prescription must be promptly reduced to writing. The prescription shall not be filled or refilled more than six months after the date thereof or be refilled more than five times, unless renewed by the practitioner.

(e) A valid prescription or lawful order of a practitioner, in order to be effective in legalizing the possession of controlled substances, must be issued in good faith for a legitimate medical purpose by one authorized to prescribe the use of such controlled substance. An order purporting to be a prescription not in the course of professional treatment is not a valid prescription or lawful order of a practitioner within the meaning and intent of this chapter; and the person who knows or should know that the person is filling such an order, as well as the person issuing it, can be charged with a violation of this chapter.

(f) A substance included in Schedule V must be distributed or dispensed only for a medical purpose.

(g) A practitioner may dispense or deliver a controlled substance to or for an individual or animal only for medical treatment or authorized research in the ordinary course of that practitioner's profession. Medical treatment includes dispensing or administering a narcotic drug for pain, including intractable pain.

(h) No administrative sanction, or civil or criminal liability, authorized or created by this chapter may be imposed on a pharmacist for action taken in reliance on a reasonable belief that an order purporting to be a prescription was issued by a practitioner in the usual course of professional treatment or in authorized research.

(i) An individual practitioner may not dispense a substance included in Schedule II, III, or IV for that individual practitioner's personal use. [2001 c 248 § 1; 1993 c 187 § 19; 1971 ex.s. c 308 § 69.50.308.]

RCW 69.41.040 Prescription requirements.
*** CHANGE IN 2003 *** (SEE 5758.SL) *** A prescription, in order to be effective in legalizing the possession of legend drugs, must be issued for a legitimate medical purpose by one authorized to prescribe the use of such legend drugs. An order purporting to be a prescription issued to a drug abuser or habitual user of legend drugs, not in the course of professional treatment, is not a prescription within the meaning and intent of this section; and the person who

knows or should know that he is filling such an order, as well as the person issuing it, may be charged with violation of this chapter. A legitimate medical purpose shall include use in the course of a bona fide research program in conjunction with a hospital or university. [1973 1st ex.s. c 186 § 4.]

RCW 69.41.042 Record requirements. A pharmaceutical manufacturer, wholesaler, pharmacy, or practitioner who purchases, dispenses, or distributes legend drugs shall maintain invoices or such other records as are necessary to account for the receipt and disposition of the legend drugs.

The records maintained pursuant to this section shall be available for inspection by the board and its authorized representatives and shall be maintained for two years. [1989 1st ex.s. c 9 § 405.]

NOTES: Effective date—Severability—1989 1st ex.s. c 9: See RCW 43.70.910 and 43.70.920.

RCW 69.41.050 Labeling requirements.
*** CHANGE IN 2003 *** (SEE 5758.SL) *** To every box, bottle, jar, tube or other container of a legend drug, which is dispensed by a practitioner authorized to prescribe legend drugs, there shall be affixed a label bearing the name of the prescriber, complete directions for use, the name of the drug either by the brand or generic name and strength per unit dose, name of patient and date: PROVIDED, That the practitioner may omit the name and dosage of the drug if he determines that his patient should not have this information and that, if the drug dispensed is a trial sample in its original package and which is labeled in accordance with federal law or regulation, there need be set forth additionally only the name of the issuing practitioner and the name of the patient. [1980 c 83 § 8; 1973 1st ex.s. c 186 § 5.]

RCW 69.41.110 Definitions. As used in RCW 69.41.100 through 69.41.180, the following words shall have the following meanings:

(1) “Brand name” means the proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging;

(2) “Generic name” means the official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary;

(3) “Substitute” means to dispense, with the practitioner’s authorization, a “therapeutically equivalent” drug product of the identical base or salt as the specific drug product prescribed: PROVIDED, That with the practitioner’s prior consent, therapeutically equivalent drugs other than the identical base or salt may be dispensed;

(4) “Therapeutically equivalent” means essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen; and

(5) “Practitioner” means a physician, osteopathic physician and surgeon, dentist, veterinarian, or any other person authorized to prescribe drugs under the laws of this state. [1979 c 110 § 1; 1977 ex.s. c 352 § 2.]

RCW 69.41.120 Prescriptions to contain instruction as to whether or not a therapeutically equivalent generic drug may be substituted—Out-of-state prescriptions—Form—Contents—Procedure. Every drug prescription shall contain an instruction on whether or not a

therapeutically equivalent generic drug may be substituted in its place, unless substitution is permitted under a prior-consent authorization.

If a written prescription is involved, the prescription must be legible and the form shall have two signature lines at opposite ends on the bottom of the form. Under the line at the right side shall be clearly printed the words "DISPENSE AS WRITTEN". Under the line at the left side shall be clearly printed the words "SUBSTITUTION PERMITTED". The practitioner shall communicate the instructions to the pharmacist by signing the appropriate line. No prescription shall be valid without the signature of the practitioner on one of these lines. In the case of a prescription issued by a practitioner in another state that uses a one-line prescription form or variation thereof, the pharmacist may substitute a therapeutically equivalent generic drug unless otherwise instructed by the practitioner through the use of the words "dispense as written", words of similar meaning, or some other indication.

If an oral prescription is involved, the practitioner or the practitioner's agent shall instruct the pharmacist as to whether or not a therapeutically equivalent generic drug may be substituted in its place. The pharmacist shall note the instructions on the file copy of the prescription.

The pharmacist shall note the manufacturer of the drug dispensed on the file copy of a written or oral prescription. [2000 c 8 § 3; 1990 c 218 § 1; 1979 c 110 § 2; 1977 ex.s. c 352 § 3.]

NOTES: Findings—Intent—2000 c 8: See note following RCW 69.41.010.

WAC 246-869-080 Clinic dispensaries. The clinics of this state shall place their dispensaries in charge of a registered pharmacist, or the dispensing must be done by each prescribing physician in person.

WAC 246-869-210 Prescription labeling. To every prescription container, there shall be fixed a label or labels bearing the following information:

(1) All information as required by RCW 18.64.246, provided that in determining an appropriate period of time for which a prescription drug may be retained by a patient after its dispensing, the dispenser shall take the following factors into account:

(a) The nature of the drug;

(b) The container in which it was packaged by the manufacturer and the expiration date thereon;

(c) The characteristics of the patient's container, if the drug is repackaged for dispensing;

(d) The expected conditions to which the article may be exposed;

(e) The expected length of time of the course of therapy; and

(f) Any other relevant factors.

The dispenser shall, on taking into account the foregoing, place on the label of a multiple unit container a suitable beyond-use date or discard-by date to limit the patient's use of the drug. In no case may this date be later than the original expiration date determined by the manufacturer.

(2) The quantity of drug dispensed, for example the volume or number of dosage units.

(3) The following statement, "Warning: State or federal law prohibits transfer of this drug to any person other than the person for whom it was prescribed."

(4) The information contained on the label shall be supplemented by oral or written information as required by WAC 246-869-220. [Statutory Authority: RCW 18.64.005. 92-12-035 (Order 277B), § 246-869-210, filed 5/28/92, effective 6/28/92. Statutory Authority: RCW 18.64.005 and

chapter 18.64A RCW. 91-18-057 (Order 191B), recodified as § 246-869-210, filed 8/30/91, effective 9/30/91. Statutory Authority: RCW 18.64.246. 85-06-010 (Order 193), § 360-16-255, filed 2/22/85. Statutory Authority: RCW 18.64.005. 84-22-027 (Order 191), § 360-16-255, filed 11/1/84.]

WAC 246-869-220 Patient counseling required. The purpose of this counseling requirement is to educate the public in the use of drugs and devices dispensed upon a prescription.

(1) The pharmacist shall directly counsel the patient or patient's agent on the use of drugs or devices.

(2) For prescriptions delivered outside of the pharmacy, the pharmacist shall offer in writing, to provide direct counseling and information about the drug, including information on how to contact the pharmacist.

(3) For each patient, the pharmacist shall determine the amount of counseling that is reasonable and necessary under the circumstance to promote safe and effective administration of the medication and to facilitate an appropriate therapeutic outcome for that patient from the prescription.

(4) This rule applies to all prescriptions except where a medication is to be administered by a licensed health professional authorized to administer medications. [Statutory Authority: RCW 18.64.005(7). 01-04-055, § 246-869-220, filed 2/5/01, effective 3/8/01. Statutory Authority: RCW 18.64.005. 92-12-035 (Order 277B), § 246-869-220, filed 5/28/92, effective 6/28/92. Statutory Authority: RCW 18.64.005 and chapter 18.64A RCW. 91-18-057 (Order 191B), recodified as § 246-869-220, filed 8/30/91, effective 9/30/91. Statutory Authority: RCW 18.64.005. 89-04-016 (Order 223), § 360-16-265, filed 1/23/89.]

WAC 246-887-020 Uniform Controlled Substances Act. (1) Consistent with the concept of uniformity where possible with the federal regulations for controlled substances (21 CFR), the federal regulations are specifically made applicable to registrants in this state by virtue of RCW 69.50.306. Although those regulations are automatically applicable to registrants in this state, the board is nevertheless adopting as its own regulations the existing regulations of the federal government published in the Code of Federal Regulations revised as of April 1, 1991, and all references made therein to the director or the secretary shall have reference to the board of pharmacy, and the following sections are not applicable: Section 1301.11-.13, section 1301.31, section 1301.43-.57, section 1303, section 1308.41-.48, and section 1316.31-.67. The following specific rules shall take precedence over the federal rules adopted herein by reference, and therefore any inconsistencies shall be resolved in favor of the following specific rules.

(2) A separate registration is required for each place of business (as defined in section 1301.23) where controlled substances are manufactured, distributed or dispensed. Application for registration must be made on forms supplied by the pharmacy board, and all information called for thereon must be supplied unless the information is not applicable, in which case it must be indicated. An applicant for registration must hold the appropriate wholesaler, manufacturer or pharmacy license provided for in chapter 18.64 RCW.

(3) Every registrant shall be required to keep inventory records required by section 1304.04 (of the federal rules which have been adopted by reference by Rule 1) and must maintain said inventory records for a period of two years from the date of inventory. Such registrants are further required to keep a record of receipt and distribution of controlled substances. Such record shall include:

(a) Invoices, orders, receipts, etc. showing the date, supplier and quantity of drug received, and the name of the drug;

(b) Distribution records; i.e., invoices, etc. from wholesalers and manufacturers and prescriptions records for dispensers;

(c) In the event of a loss by theft or destruction, two copies of DEA 106 (report of theft or loss of controlled substances) must be transmitted to the federal authorities and a copy must be sent to the board;

(d) For transfers of controlled substances from one dispenser to another, a record of the transfer must be made at the time of transfer indicating the drug, quantity, date of transfer, who it was transferred to and from whom. Said record must be retained by both the transferee and the transferor. These transfers can only be made in emergencies pursuant to section 1307.11 (federal rules).

(4) The records must be maintained separately for Schedule II drugs. The records for Schedule III, IV and V drugs may be maintained either separately or in a form that is readily retrievable from the business records of the registrant. Prescription records will be deemed readily retrievable if the prescription has been stamped in red ink in the lower right hand corner with the letter "C" no less than one inch high, and said prescriptions are filed in a consecutively numbered prescription file which includes prescription and noncontrolled substances.

(5) A federal order form is required for each distribution of a Schedule I or II controlled substance, and said forms along with other records required to be kept must be made readily available to authorized employees of the board.

(6) Schedule II drugs require that a dispenser have a signed prescription in his possession prior to dispensing said drugs. An exception is permitted in an "emergency." An emergency exists when the immediate administration of the drug is necessary for proper treatment and no alternative treatment is available, and further, it is not possible for the physician to provide a written prescription for the drug at that time. If a Schedule II drug is dispensed in an emergency, the practitioner must deliver a signed prescription to the dispenser within 72 hours, and further he must note on the prescription that it was filled on an emergency basis. [Statutory Authority: RCW 43.70.280. 98-05-060, § 246-887-020, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.64.005. 92-04-029 (Order 239B), § 246-887-020, filed 1/28/92, effective 2/29/92. Statutory Authority: RCW 18.64.005 and chapter 18.64A RCW. 91-18-057 (Order 191B), recodified as § 246-887-020, filed 8/30/91, effective 9/30/91. Statutory Authority: RCW 69.50.201. 89-17-023 (Order 226), § 360-36-010, filed 8/8/89, effective 9/8/89. Statutory Authority: RCW 69.50.301. 87-10-029 (Order 206), § 360-36-010, filed 5/1/87. Statutory Authority: RCW 18.64.005(4). 85-06-010 (Order 193), § 360-36-010, filed 2/22/85. Statutory Authority: RCW 69.50.301. 80-05-074 (Order 154, Resolution No. 4/80), § 360-36-010, filed 4/28/80; 79-10-007 (Order 151, Resolution No. 9/79), § 360-36-010, filed 9/6/79. Statutory Authority: RCW 69.50.301 and chapter 69.50 RCW. 78-02-070 (Order 140), § 360-36-010, filed 1/25/78; Order 132, § 360-36-010, filed 5/4/77; Order 108, § 360-36-010, filed 10/26/71.]

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Department of Health
Washington State Board of Pharmacy

P.O. Box 47863
Olympia, Washington 98504-7863
(360) 236-4828

Drug Storage, Prescribing And Dispensing Guidelines

Legend Or Prescription Drug Procedures For Practitioners

Drug Storage:

All drugs that require a prescriber's authorization for legal possession must be secured to prevent unauthorized acquisition.

Prescription Blanks:

Practitioners must secure their prescription blanks to reduce the possibility of the forms being used illegally. Forgeries are a real problem.

Prescription blanks in Washington State are required to have two signature lines at opposite ends on the bottom of the form. Under the line at the right side shall be clearly printed the words **"DISPENSE AS WRITTEN."** Under the line at the left side shall be clearly printed the words **"SUBSTITUTION PERMITTED."** The practitioner shall communicate the instructions to the pharmacist by signing the appropriate line. No prescription shall be valid without the signature of the practitioner on one of these lines.

Dispensing:

Washington practitioners are authorized to dispense the drugs which they prescribe. They may **NOT** delegate this function to a nurse or other staff member. In addition, in a group practice, one practitioner may **NOT** be designated to dispense the drugs for all of the practitioners. This is considered to be the practice of pharmacy and may only be done by a pharmacist.

A practitioner who purchases, dispenses, or distributes legend drugs shall maintain invoices or such other records as are necessary to account for the receipt and disposition of the legend drugs. The records shall be maintained for two years and shall be available for inspection by the board and its authorized representatives.

If a practitioner dispenses, he/she needs to be aware of labeling and record keeping requirements. The law (RCW 69.41.050) requires that practitioners place at least the following information on the label:

1. Name of prescriber
2. Name of the patient
3. Complete directions for use
4. Name of the drug (brand or generic)
5. Strength of drug per dose
6. Date of dispensing

Note: The name and strength may be omitted if the practitioner determines that the patient should not have this information, however, this is rarely the case anymore.

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Controlled Substance Procedures For Practitioners

If the drug is a trial sample and is being distributed in its original package, the practitioner need only add his/her name along with the patient's name.

Note: We find that this law is commonly violated. Practitioners must improve their practices in the area of labeling samples and other drugs that they dispense.

Packaging:

Patients should be able to expect the same packaging of drugs from a prescriber as they are able to obtain from a pharmacist. Paper envelopes and boxes are unacceptable containers for drugs. The use of tight, light resistant glass or plastic containers is required to assure the stability and integrity of today's drugs. In addition, the use of Child Resistant Caps (CRC's) should be the rule rather than the exception. There is a direct correlation between the use of CRC's and the reduction in the poisoning of children.

Prescribing:

Controlled substances may only be prescribed for therapeutic purposes. You may not prescribe a controlled substance to maintain addiction or to detoxify an addict. Care must be taken when treating "drug addicts" for other medical problems. Methadone may be used to treat pain, however, only a narcotic treatment program which is registered with both the FDA and DEA may use methadone for detoxification or maintenance treatment.

Practitioners may NOT prescribe controlled substances for themselves.

Purchasing:

A practitioner may NOT use a prescription form to order controlled substances for administration or dispensing. For Schedule II drugs, a special triplicate order form must be used (DEA form 222). Drugs in other schedules may be ordered in whatever manner is required by the seller (e.g., pharmacy, wholesaler, manufacturer, etc.).

Storage:

According to the DEA, controlled substances must be stored in a "securely locked, substantially constructed cabinet." For the usual quantities of these drugs which might be stored in a practitioner's office, a locked desk, file cabinet with a lock, locked wood or metal cabinets or a small safe could qualify as secure storage.

Administering:

Practitioners may administer controlled substances to their patients in the practitioner's office. Records must be maintained.

Records:

Practitioners who dispense and/or administer controlled substances must maintain records to account for the receipt and disposition of these drugs. The Dental Disciplinary Board has developed specific rules regarding the format for these records (See WAC 246-816-050; 060; & 070). Other boards have NOT done this. Therefore, other professionals need only to follow DEA rules.

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Records must be “readily retrievable.”

Although your patient records should contain detail regarding all drugs prescribed or dispensed, this site would not be considered to be “readily retrievable.”

A separate log or record should be maintained to show the name of the patient, name, strength and quantity of drug dispensed, the date of dispensing and the name or initials of the person dispensing or administering the drug. This log shall also indicate detail regarding any receipt of controlled substances.

Invoices, official order forms, and receipts for controlled substances must also be maintained. Having a separate file or hi-lighting the controlled substances to differentiate them from other drugs makes these records “readily retrievable.”

A complete inventory of all controlled substances must be performed and documented every two years. It must be in writing, dated, and signed by the person taking the inventory. If you have never taken an inventory, it should be performed as soon as possible. Biennial inventories shall be performed on the same day on subsequent years. All controlled substances, including samples, must be counted.

All losses of controlled substances must be reported to the DEA and to the Board of Pharmacy.

Outdated, deteriorated, and unwanted controlled substances must be disposed of in compliance with the law. These drugs may not be discarded or destroyed. Contact the DEA (206) 553-4040 or the Board of Pharmacy for specific forms and instructions.

Of necessity, this summary does not include all of the laws and rules regarding controlled substances. It is suggested that practitioners contact the DEA, the Board of Pharmacy, or their own licensing board to discuss specific issues related to this topic.

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Nursing Web Addresses

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Web Pages

Following are some Web pages you may find useful for nursing information.

- https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm—Nursing Care Quality Assurance Commission home page
- http://www.doh.wa.gov—Department of Health
- www.ncsbn.org—National Council of State Boards
- www.wsna.org—Washington State Nursing Association
- www.nursingworld.org—American Nurses Association
- http://slc.leg.wa.gov/default.htm—Code Reviser Office—Access any statute or rule
- www.egroups.cm/list/world-research-nurses—Nursing related searches
- www.nurseadvocate.org—Nursing e-mail discussion list
- http://www.curtincalls.com/Frame/LeahsLinks/default.htm—Leah Curtin, Editor-in-Chief of *Nursing Management* for 20 years, now publishes CurtinCalls, an irreverent, fact-filled scan of nursing and health care in the United States.
- www.ihi.org—The Institute for Healthcare Improvement (IHI) is a not-for-profit organization created to help lead the improvement of health care systems, to increase continuously their quality and value.
- http://www.lni.wa.gov/scs/workstandards/nurseot.htm for further information on the frequently-asked questions and implementation of the mandatory overtime legislation which became effective June 2002 in Washington State.

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School Nursing Information

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Washington State Nursing Care Quality Assurance Commission

Washington State Office of Superintendent of Public Instruction

Washington State Department of Health

Mary Selecky
Secretary
Department of Health

Dr. Terry Bergeson
State Superintendent of Public Instruction

April 2000

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Dr. Terry Bergeson
State Superintendent of Public Instruction

Thomas J. Kelly
Assistant Superintendent
Operations and Support

Marcia L. Riggers
Director, Education Support

Judith A. Maire
Program Supervisor
Health Services

April 2000

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Staff Model For The Delivery Of School Health Services

Mary C. Selecky, Secretary
Washington State Department of Health

Maxine Hayes, MD, MPH, Health Officer
Washington State Department of Health

Ronald Weaver, Assistant Secretary
Washington State Department of Health

Susan Shoblom, Director
Washington State Department of Health

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Staff Model For The Delivery Of School Health Services

Acknowledgments

This staff model was developed from a series of public meetings. The public meetings were attended by representatives of hospitals, university schools of nursing, state and local health and education agencies and organizations, student advocacy organizations, parents, and professional organizations representing school staff. These stakeholders provided valuable input and support in the development of this document.

We would also like to thank the following for their contributions to this model and recognize their continuous contributions to the students of the state of Washington. Their professionalism and dedication make it possible for all children in kindergarten through Grade 12 to have their health care needs assessed and addressed while their educational needs are met.

Barbara Cheyney, R.N.C., M.S.
Coordinator of Health Services
Highline School District

Marilyn Fenn, R.N., B.S.N.
President, School Nurse Organization of Washington

Shannon Fitzgerald, R.N., M.S.N., A.R.N.P.
Washington State Nursing Care Quality Assurance Commission

Linda Graham, R.N., B.S.N.
School Nurse
Mukilteo School District

Judith A. Maire, R.N., M.N.
Health Services Program Supervisor
Office of Superintendent of Public Instruction

Diane Martin, R.N., M.N.
Nursing Director
Lincoln County Health Department

Paula R. Meyer, R.N., M.S.N.
Executive Director
Washington State Nursing Care Quality Assurance Commission
Department of Health

Anne St. Germaine, R.N., Ph.D.
Comprehensive Health Manager
Seattle School District

Norma Wells, RDH, M.P.H.
Associate Professor and Director, Dental Hygiene Program
University of Washington
Washington Oral Health Coalition

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Staff Model For The Delivery Of School Health Services

Introduction

This document is divided into three sections. The first is a general discussion of nursing care in schools and the different levels of staff who may provide health services in terms of their training, education, licensure, certification, and responsibility. The staff model is two parts as described in the summary below.

Summary: The staff model consists of a nursing assessment to determine levels of care needed for individual students in a school and an overall school district model with staffing level recommendations. The staff model is two parts: (1) "Levels of Nursing Care for Student Diseases and Conditions: Severity Coding," a nursing assessment to determine levels of care needed for individual students in a school, and (2) "School District Model for the Delivery of Health Services," an overall school district model with staffing level recommendations. The staff model is to be used to predict the nursing care and staff needs of individual schools and school districts.

In the school setting, it is essential to aggressively manage any health problems that are likely to comprise daily learning readiness. For this reason, school health care providers may prioritize concerns and assign health services staff somewhat differently from the traditional medical community.

I. Nursing Care In Schools

The school nurse's primary responsibility is to the students. Each school nurse is responsible for each component of the nursing process with children in school: assessing, planning, implementing, and evaluating the nursing care. This is a continuous process. The registered nurse is responsible for the initiation of the care plan. In order to complete the initial care plans, the registered nurse(s) must be alerted to the needs of the child(ren) who will attend school. Optimally, these needs would be identified and communicated prior to attendance at the school to allow for adequate planning and training of school personnel. Administrators (including special education) in each school must establish a procedure that identifies and communicates the student's actual or potential need(s) for nursing care to the registered nurse. The identification of these needs, at the port of entry, can be communicated through health forms, parents' messages to school administrative personnel, or the health room personnel. Time to assess the needs of children and develop the plans must be considered as additional to the time needed to provide the actual care.

Components of a nursing assessment are:

- Patient interview.
- Review of Physical Systems.
- Family history.
- Physical examination.
- Psychological nursing assessment (review of support systems, mental health assessment, etc.).
- Patient's compliance history.
- Understanding of procedures and outcomes.
- Physical environmental assessment.
- Functional assessment.
- Review of current medical diagnoses.
- Developmental assessment.
- Review of medications, interpretation of side effects, identification of effects on patient outcome (pharmacological assessment).
- Identification and interpretation of deviations from physiological norms.
- Interpretation of the impact of patient's medical history and treatment modalities on the patient's current condition.
- Evaluation of effectiveness of current treatment modalities.

From the information obtained in this nursing assessment, the nurse develops nursing diagnoses, a plan of care specific to the student, and provides for the implementation of the plan of care and ongoing evaluation. The plan of nursing care, often referred to as an individual health care plan (IHP), is a component of the interdisciplinary plan of care for a patient. The registered nurse is responsible for the "plan of nursing care" component of the interdisciplinary plan. (Excerpt from Washington State Board of Nursing, *Unlicensed Practice Task Force Recommendation*, March 1991)

L.P.N./R.N. Preparation

Licensed practical nurses (L.P.N.) use specialized knowledge, skill, and judgment to carry out selected aspects of the designated nursing regimen under the direction and supervision of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, physician assistant, osteopathic physician assistant, podiatric physician and surgeon, advanced registered nurse practitioner, or registered nurse (RCW 18.79.060). L.P.N.s are fully licensed health professionals and are accountable for their own actions at all times. L.P.N.s may give medications in school settings, including injections, with indirect registered nurse (R.N.) supervision. WAC 246-840-705 describes the functions of a licensed practical nurse. In summary, a licensed practical nurse recognizes and meets basic client needs in routine nursing situations, which are defined as situations that are relatively free of scientific complexity, involving stable and predictable client conditions. L.P.N.s also function in more complex nursing care situations, and in these cases an L.P.N. would function as an assistant to the registered nurse or physician. Licensed practical nurses can revise the care plan and deliver the care according to the plan.

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As stated above, indirect supervision by an R.N. who is not on school premises is within the standards of care, as long as the L.P.N. is providing the care for students in routine, noncomplex situations and as long as the supervisory role of the R.N. has been established. Periodic review of the plan and R.N. availability for questions are recommended components of school health services.

A registered nurse has the knowledge, skills and license to provide nursing care. The registered nurse may have either a bachelor's of science in nursing (BSN), an associate degree in nursing (ADN), or a diploma from a hospital school of nursing. Registered nurses with a BSN possess the knowledge and skills to function independently in a community or school setting and to coordinate family and community service in managing students with significant health problems.

The Certified School Nurse Employed by a School District

The registered nurse with educational staff associate (ESA) certification as a school nurse has the preparation to develop and administer a comprehensive school health program, contribute to the development and teaching of the health education program, and is familiar with school law and the implications for school nursing practice. The certificated school nurse has the knowledge and skills to perform and supervise nursing care of students. The knowledge and skills acquired through the certification process (WAC 180-79A-223[1]) are over and above the knowledge and skills required for licensure as a R.N. and that generally obtained in a BSN program. Persons serving as school nurses in first class districts must hold an ESA certificate (WAC 180-86-011). WAC 180-87-050, Misrepresentation or Falsification in the Course of Professional Practice, addresses professional misconduct by a person (such as a school nurse) acting as a nurse without the valid, appropriate certification.

For an employer (such as a school administrator), WAC 180-87-070(1) defines an act of unprofessional practice as the intentional employment of a person to serve as an employee in a position for which certification is required by rules of the State Board of Education when such person does not possess a valid certificate to hold the position for which such person is employed.

WAC 180-87-070(2) further defines an act of unprofessional practice as "The assignment or delegation in a school setting of any responsibility within the scope of the authorized practice of nursing, physical therapy, or occupational therapy to a person not licensed to practice such profession unless such assignment or delegation is otherwise authorized by law, including the rules of the appropriate licensing board." Nursing care can only be delegated by the R.N. within the regulations and guidance of the Nursing Care Quality Assurance Commission.

Other certificates are available within certain restrictions if an R.N. has no BSN. See WAC 180-79A-231(1)(c)(iii).

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Delegation of Nursing Care

Properly credentialed health care professionals, including R.N.s and L.P.N.s, are able to work in the school settings, but must act within the scope of their respective practice acts. Licensed health care professionals must also comply with any specific laws that apply to the provision of health care in the school setting, laws that may be more or less restrictive than in other settings. For instance, registered nurses may delegate certain limited health care tasks to uncredentialed school employees so long as the registered nurse and the employee comply with delegation, training, and supervision requirements addressed in RCW 28A.210.260 and 28A.210.280. Under these laws, uncredentialed school employees may administer oral medications and perform clean intermittent catheterizations as delegated tasks, tasks that in other settings could not be lawfully performed by uncredentialed individuals. Registered or certified nursing assistants (and health care assistants) are not authorized to practice in the school setting, but they may function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations. Therefore, nursing assistants (and health care assistants) would be limited to the performance of only those tasks they could complete as uncredentialed school employees under RCW 28A.210.260 and 28A.210.280.

If the nursing assistant or licensed practical nurse completes other tasks, he or she would then need to comply with all of the regulations that govern their practice. Schools are not included in the list of health care facilities as determined by the Washington State Nursing Care Quality Assurance Commission. Therefore, a nursing assistant's practice would be limited to the tasks he or she could complete as a school employee.

In the process of determining the appropriateness of nurse delegation in schools, the registered nurse uses his/her judgment to determine the competency of the individual accepting the training to complete a delegated task. The person to whom the R.N. delegates care must be trained, willing, and competent to accept the delegation of a nursing task or care. In every instance, the nurse retains responsibility to the student for the quality of nursing care provided by the delegatee. If in the judgment of the registered nurse, the caregiver is not able or willing to complete the task, the caregiver is not considered competent and must not provide the care. Delegation and supervision are both part of the assessment phase in nurse delegation. The registered nurse evaluates the competency of the caregiver on a regular basis and therefore assesses the safety and efficacy of the caregiver providing the care. References to this are in RCW 18.79.040(1)(c) and RCW 18.79.260(2).

IDEA/Section 504 Staffing Accommodations

For students who have qualified for special education, the requirements of the Individual with Disabilities Education Act (IDEA) and state law for development of the individualized education program (IEP) and for the provision of health and education services in the least restrictive environment must be met.

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For students who do not require special education, Section 504 of the Rehabilitation Act of 1973 requires students with a disability to have full access to all activities, services, or benefits provided by public schools. Any school receiving federal funds must accommodate the special health care needs of its students with disabilities in order to provide them with a "free appropriate public education." Such accommodations should be documented in an appropriately developed Section 504 plan or, if the child also needs special education or related services, in an IEP. These accommodations must be developed with parental input and cannot be implemented without parental consent. The school district has a legal obligation to ensure that these accommodations are provided as described in the Section 504 plan.

Confidentiality of Health Care Information

All unlicensed health care providers, such as health room aides or pupil transportation staff who assist the health care provider in the delivery of health care to students, must be informed of the confidentiality requirements of the federal Family Education Rights and Privacy Act (FERPA) and state requirements under chapter 70.02 RCW, Medical Records—Health Care Information Access and Disclosure. Health care information about a student cannot be disclosed without a signed consent of parent, guardian, or student except in selected situations identified by the licensed health care provider (such as the school nurse). See *Guidelines for Handling Health Care Information in School Records,* State of Washington, Superintendent of Public Instruction, September 1995.

II. Levels of Nursing Care for Student Diseases and conditions: Severity Coding

Students attend school with a broad range of health conditions, from potentially life-threatening acute and chronic conditions to correctable vision problems and everything in between which could impede the student's ability to fully participate in the educational process. Severity coding is a method for planning adequate staffing to meet the varying needs of students.

Severity of condition does not always translate directly into nursing time with the students. Many students with significant chronic conditions **predictably** require daily nursing time. For example, a student with spina bifida who is not yet independent with urinary bladder management requires 40 minutes every day of the nurse's time for catheterizations at the same time every school day. Other students such as those with severe asthma may experience an acute attack and require nursing assessment and care **at any time** during a school day.

Examples of treatments/interventions that may be performed in schools at all levels of severity are (these are only a few examples and not meant to be an exclusive list):

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Blood glucose test
Continuous oxygen administration
Dressing change
Gastric tube feeding
Intermittent oxygen administration
Laboratory tests
Medication management
Monitor blood pressure
Monitor disability
Monitor illness
Monitor weight
Nebulizer treatments
Peak flow monitoring
Sterile bladder catheterization
Suctioning
Toileting
Tracheostomy care
Unsterile bladder catheterization

In order to plan, care for, and monitor the students with special health care needs, the school nurse will assign each qualifying student to a level of care based on the following categories: nursing dependent, medically fragile, medically complex, and health concerns. In addition to children being considered for assignment to these levels of severity, there are many other students not requiring care on a daily basis. Therefore, the School District Model for the Delivery of Health Services (pages 12–14) has been recommended for this larger population of students. This model is to be used in conjunction with severity coding which establishes the nursing staff needs of students within a school building.

Level A: Nursing Dependent

Nursing dependent student require 24 hours/day, frequently one-to-one, skilled nursing care for survival. Many are dependent on technological devices for breathing, for example, a child on a respirator, and/or continuous nursing assessment and intervention. Without effective use of medical technology and availability of nursing care, the student will experience irreversible damage or death. Before a student enters school, a registered nurse will complete a nursing assessment of the student and determine an appropriate plan of care/individual health care plan.

Staffing requirements: Immediate availability of the nurse (registered nurse or licensed practical nurse as determined by the R.N.) “on the premises and is within audible an visual range of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any care giver” (WAC 246-840-010[11][d]).

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

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Level B: Medically Fragile

Students with complex health care needs in this category face daily the possibility of a life-threatening emergency requiring the skill and judgment of a professional nurse. An individual health care plan or plan of nursing care developed by a registered nurse must be complete, current, and available at all times to personnel in contact with these children. This includes bus drivers for daily transportation adn special events, sports coaches, and school personnel assigned to extracurricular activities. Every child in this category requires a full-time nurse in the building. Children in this category may be transported to school. Someone must be trained and available on the bus to provide care during transport to the school. This training must include the primary bus driver, the child, and backup personnel. The registered nurse makes the decision of who will be trained and what level of preparation is required, and uses the nurse delegation principles described on pages 4–5.

Examples may include, but are not limited to:

- Severe seizure disorder, requiring medications that can be administered only by a nurse.
- Severe asthma with potential for status asthmaticus.
- Sterile procedures.
- Tracheostomy with frequent and/or unpredictable suctioning.
- Unstable and/or newly diagnosed diabetic with unscheduled blood sugar monitoring and insulin injections.

Staffing requirements: Every child in the medically fragile category requires a full-time nurse in the building. The nurse “is on the premises, is quickly and easily available and the patient [student] has been assessed by the licensed registered nurse prior to the delegation of the duties to any caregiver.” (WAC 246-840-010[11][c]).

The child may need to transfer to a school where full-time nursing staff is provided if not available at the local school. If the child needs a high level of nursing service, but is not willing to move or the parents object to the move to the school where the service is provided, the parents, school administrators, and school nurse should meet and discuss options. Options **may** include a waiver signed by the parent in compliance with school district policy for the student to remain in the local school. In these cases, a move toward students attending their neighborhood schools works against the provision of adequate care if there is not a full-time nurse in the neighborhood school. Parents need to be fully aware of the services that are offered by a school. Placement of their children in schools where services are not available to the degree required, could present undue stress on the child, the nursing staff, parents, and school staff. If a waiver has been signed, the professional registered nurse in the school the child is attending must be aware of the child’s condition and needs and develop emergency care plans for these children. Reasonable accommodation and provision of education and health services under Section 504 or under IDEA must be considered and addressed in each child’s individual health care plan.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level C: Medically Complex

The medically complex student has a complex and/or unstable physical and/or social-emotional condition that requires daily treatments and close monitoring by a professional registered nurse. Life-threatening events are unpredictable. Treatments, medications, and reporting of current signs and symptoms can be delegated, but delegation requires a trained, willing, adn competent staff person and close supervision of that staff person by a registered nurse. The level of supervision required is determined by the R.N. but most be adequate to maintain safety and ensure competence of the direct caregiver. Adaptations of the medically complex student to the educational system must be negotiated and maintained with the student, family, school staff (classroom and administrative), and community health care provider(s).

Examples include, but are not limited to:

ADHD and on medications
Anaphylactic event
Cancer
Complex mental or emotional disorders
Immune disorders
Moderate to severe asthma; inhaler at school and peak flow meter
Oxygen, continuous or intermittent
Preteen or teenage pregnancy
Taking carefully timed medications
Taking medications with major side effects
Unstable metabolic conditions

Emotional disorders and homicidal and/or suicidal behaviors may be assessed and categorized at this level. These conditions require collaboration with school counselors. The registered nurse's role must be identified and defined and mutually agreed to in these cases. Pregnancy may be classified at this level. Pregnancy issues must be assessed and may require weekly evaluation.

Staffing requirements: Children placed in this category require a professional registered nurse in the building a full day a week who is available on a daily basis when not in the school building. The registered nurse prioritizes issues weekly and provides a face-to-face assessment of these children at least one day a week. If children in this category become more fragile and meet the definition of Level A or Level B care, they may need to transfer to a school that meets the

staffing requirements of the higher categories. This is dependent on the registered nurse's judgment and district policy. At Level C, the registered nurse "is not on the premises but has given either written or oral instructions for the care and treatment of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any caregiver" (WAC 246-840-010[11][e]). If any alteration of the written care plan is required, it must be done by the registered nurse and must be documented. Licensed practical nurses can revise the care plans and consult with the registered nurse.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level D: Health Concerns

The student's physical and/or social-emotional condition is currently uncomplicated and predictable. Occasional monitoring is required. Require monitoring varies from biweekly to annually. Examples include, but are not limited to:

Dental disease
Diabetes self-managed by the student
Dietary restrictions
Eating disorders
Encopresis
Headaches, migraines
Sensory impairments
Orthopaedic conditions requiring accommodations
Uncomplicated Pregnancy

Staffing requirements: Children placed in this category should have their health needs assessed at least once a school year by the registered nurse at the beginning of the school year or at the time of diagnosis. Reassessment occurs as the condition requires and the nurse's judgment determines.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
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Social/Emotional Factors, Comorbidity

Classification of students by the severity of their condition(s) remains the responsibility of the registered nurse. The registered nurse may factor into his/her decision any of the following or other significant factors that increase health care need:

Chronic illness stressors	Homeless
Drug/alcohol stressors	Poverty/low income
English-as-second language	Reentry
High mobility/turnover	Special education, enrolled

The student's diagnosis may place him or her at Level D, but if the student has more than one diagnosis (comorbidity) or any of the above risk factors, the nurse may place the student in a higher level of severity and increase monitoring, at least initially.

Transportation

A student may need transportation as a related service, as determined under procedures provided under IDEA and chapter 392-172 WAC, because of student characteristics which could require nursing care, or intervention, or require the use of adaptive or assistive equipment. In these situation, the pupil transportation staff should be invited to participate in the nursing assessment and care planning process as a resource person and potential provider of care.

Time allotted for training by the registered nurse and for the pupil transportation personnel needs to be considered in the staffing model. Informing and training transportation staff prior to the first transport is essential to ensure safe transport. The degree of ongoing nursing supervision must also be addressed and provided. Appropriate substitutes for the transportation personnel must be trained as well. Liability questions associated with the provision of nursing care and supervision need to be addressed. The registered nurse will assess the student and secure answers to the following questions prior to transportation arrangements being made:

1. Can the student be safely transported?

2. Can the student's medical equipment be transported?

3. What in-service training is necessary to safely transport this student, e.g., use of medical equipment, signs and symptoms of illness or disease progression, universal precautions, etc.?

4. Is an additional staff person necessary in the vehicle to observe and care for the student during transport?

5. What level and degree of nursing supervision is required by the transportation staff for the student?

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Level C or D students may require some adaptations but not require nursing staff to be on the bus. If a student in Level C or D experiences deterioration in condition or an acute episode requiring increased nursing care, the nurse will reassess the student. If the student is then categorized as Level A or B, the student may be transported to a school with full-time nursing services depending on district policy and/or additional or licensed personnel resources may be added to the bus.

III. School District Model for the Delivery of Health Services

In this section we will discuss the second part of the staff model which describes a district-wide staffing model. “Levels of Nursing Care for Student Diseases and Conditions: Severity Coding” determines health services staffing for students within a school building based on the student’s condition and the nursing services the student requires during the school day (pages 6–12). The following “School District Model for the Delivery of Health Services” provides recommendations for district-wide staffing for health services.

- One professional school nurse for every 1,500 regular education students, including those on the health concerns level (Level D).
- A health room paraeducator to student ratio based on the grade level within a building.
- Additional assigned professional registered nurses, L.P.N.s, and unlicensed school staff to whom the care of students on Levels A, B, and C have been delegated based on individual student need as determined by the registered nurse’s assessment.

Certificated School Nurses

The certificated school nurse could be expected to have the abilities because of her/his educational preparation (see page 4) for the activities described here. The school nurse with educational staff associate (ESA) certification has responsibility for assessing the health care needs of all 1,500 students, in his/her caseload; assigning students to an appropriate level (A-D); delegating the care to R.N.s L.P.N.s, and unlicensed school staff; and providing appropriate training and supervision of the caregiving staff. The school nurse participates as a member of each student’s evaluation group, which includes parent(s), participates in the development of the student’s IEP, and ensures the implementation of the health care aspects of the IEP. For students not receiving special education, the nurse develops an IHP. The nurse participates in the development of health education curricula and teaches classes when appropriate. The nurse evaluates and monitors the school environment for health and safety hazards and works with the local health department in the control of communicable disease and the monitoring of student immunization against vaccine-preventable disease.

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The school nurse recommends or designs accommodations (Section 504 Plan) that permit the student to participate fully in learning and communicates to school staff to ensure understanding and compliance with the student's educational program goals. The school nurse ensures that each student in his/her caseload is well enough to learn each school day and that any student and family health issues that may increase absences or negatively affect the student's ability to learn are identified and addressed.

The school nurse provides case management for students in his/her caseload and interacts with parents, primary health care providers, community and school resources to provide a school environment that is safe, healthy, and conducive to learning.

The school nurse in this role should have current ESA certification in order to meet the basic requirements for managing the health care of 1,500 students within the educational system and culture.

Non-ESA Certificated Nurses/L.P.N.s

As previously discussed on pages 3–5, other registered nurses and licensed practical nurses can work in the school settings without the ESA certificates. Licensed practical nurses work under the supervision of R.N.s, physicians, and other authorized health care providers.

Health Room Assistants

The health room assistant (HRA) is specially trained to staff the health room and provide care to students based on protocols developed and supervised by the registered nurse. The HRA has completed the Office of Superintendent of Public Instruction (OSP) "Orientation-Level Training for Paraeducators Working with Students with Special Health Care Needs" course. The HRA may be a registered or certified health care provider which would require the HRA to act within her/his scope of practice with the exception of clean intermittent catheterization and oral medication administration (see page 5) and comply with the Uniform Disciplinary Act.

The health room assistant is in the building daily at least during the high use times such as 11 a.m.—1 p.m. when most medications are given. The recommended ratio is:

1. Elementary schools—at least 0.1 FTE/100 students.
2. Middle and high schools—at least 0.1 FTE/200 students.

Up to a limit of one HRA per building is recommended. The HRA may be in the school at times the school nurse is not, but there must be provision for at least weekly face-to-face communication with the school nurse on a routine, scheduled basis. The R.N. has responsibility for selection, training, and supervision of the

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HRA and for the development of health room protocols. The hiring and performance evaluation of the HRA remains with the school administration with weighted comments from the supervising R.N. in health care provision by the HRA. As indicated in the introduction, however, registered/certified nursing assistants and certified health care assistants are not authorized to practice in the school setting; they may function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations under RCW 28A.210.260 and 28A.210.280.

Clerical Staff

For the nursing staff to complete nursing responsibilities, clerical staff are needed as support for filing the individual health plans, data entry, and ensuring that the health forms and immunization records are completed.

Summary

This paper provides a discussion of an approach to the hiring and assignment of staff for the provision of school health services that considers the individual student nursing care needs during the school day, plus the need for school nurse services by all students within a district.

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 Quince Street SE • PO Box 47864 • Olympia, Washington 98504-7864

Washington State
Department of Health
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia, WA 98599-7864
January 31, 2002

Contact: Paula Meyer, Executive Director
(360) 236-4713

Numerous calls and inquiries to the Washington State Nursing Care Quality Assurance Commission have been received recently about the management of diabetes in school settings in Washington state. Specifically, concerns have been raised about the use of glucagon, a medication which must be mixed and injected, in cases of severe hypoglycemia (low blood sugar) and seizure.

Several years ago, the Washington State Nursing Care Quality Assurance Commission worked closely with Mary Bridge Children's Hospital, Children's Hospital in Seattle, the Office of the Superintendent of Public Instruction, the School Nurse Organization of Washington, and the Washington State Diabetes Association to develop a comprehensive set of guidelines and extensive teaching materials for all personnel in schools regarding the care of students with diabetes. Part of the guidelines include a set of advisory opinions issued by the Nursing Commission regarding the scope of practice of registered nurses with regard to delegation of certain skills and tasks related to the continuum of care for students.

Registered nurses may delegate various tasks of nursing care to other individuals in a variety of settings. However, registered and practical nurses cannot delegate tasks of nursing care which involve injections, medications, and other potentially complex tasks to anyone unless there is a provision in state law which would allow the person in question to perform the procedure. A major exception to this law involves situations in which family members provide nursing care for each other, such as in hospice care, when family members may be taught by nurses to adjust pain medication and intravenous feedings.

Concerned citizens have called the Commission wondering why the Commission is preventing the use of glucagon in schools. Callers should be aware that t**he Nursing Commission does not have the authority to issue a ruling to allow nurses to teach non family members to give shots in any setting**. Such a change would be up to the State Legislature; the Nursing

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Commission's advisory opinion regarding glucagon was designed to clarify the existing rule for practicing nurses.

Interested parties are invited to review the document the committee created, *Guidelines for Care of Students with Diabetes*, published in September, 2001 (see below for access information). The document reflects an evidence-based approach to the design of care plans for each student based on developmental status, medical treatment plan, and consultation with parents. Promotion of health and a normal school experience for each child with diabetes were the goals for the committee. The idea is to provide plenty of education and resources for all school personnel who may work with a student with diabetes on a given school day, from the bus driver to the playground assistant. All personnel can then recognize impending problems like low blood sugar that can be easily identified and corrected, and crises can be averted.

Severe hypoglycemic states with seizures have been rarely reported in school settings. The general plan for such emergencies is activation of the EMS system. A student who may be seizing as a result of too much insulin and/or too little food might require a variety of interventions beyond the glucagon injection, and would need to be monitored closely.

The Nursing Commission is pleased to have been part of the development of the guidelines for students with diabetes and hopes that cooperation and collaboration mark future endeavors. Innovative solutions to school staffing can also be found in the guidelines as well. One school district hired a licensed practical nurse as a classroom aide who could assist a student under the supervision of the registered school nurse.

INFORMATION:

Guidelines for Care of Students with Diabetes
Office of Superintendent of Public Instruction
Old Capitol Building
P.O. Box 47200
Olympia, WA 98504-7200
1-888-595-3276

http:/www.k12.wa.us/LearnTeachSupp/healthservices/ in pdf format (Adobe Acrobat required)

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Section XI
Frequently Asked Questions

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Top Five Licensing Questions

Q Have you received my renewal?

A It takes about one week before the staff receive your renewal. Mail goes through the U.S. Postal Service and then through the State Mail Service. The check then has to clear the bank which takes an additional two days. So give the staff at least one week to receive your renewal, a couple of days to process it and about 4 days for mailing back to you.

Q What's the quickest way to get my license in Washington?

A Download the application form and instructions from our web site at www.doh.wa.gov/ https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/forms.htm. Mail in your application with an original signature and the requested documentation. If all documentation is submitted you should have your license in about 2-3 weeks. Typical delays involve the license verification from another state, if endorsing.

Q I don't have a social security number. How can I get licensed and why do you need it anyway?

A You must have a social security number to become licensed in Washington. Contact the Social Security Administration at 1-800-772-1213. A statute in Washington requires all health care professions to collect the social security number for defaults on child support and student loan defaults. The social security number must be collected on all applicants regardless of whether you have any children or have ever received a student loan. The SS# is not releasable to another agency or to the public.

Q I have a felony in my past. Will that stop me from getting my nursing license?

A The existence of a felony does not automatically preclude you from getting licensed. The Nursing Commission will decide at the time you apply and will base their decision on the information you provide, a copy of the conviction record, the length of time since the conviction and whether or not there have been subsequent convictions.

Q Why does it cost so much to reactivate?

A The cost includes your renewal, the penalty fee and the cost of reissuance. This fee includes costs for additional telephone calls, license verification, writing letters, data entry and additional time. Reactivating a license involves a lot more work and requires a lot of work that would normally be automated, to be done by hand.

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Section XII
Overlapping Scope of Practice

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Overlapping Scope of Practice

Problem:

Questions frequently come to boards, commissions and staff from practitioners or health care consumers regarding what is permissible within a particular health profession scope of practice. The board, commission, or staff to secretary professions, interprets individual practice acts (laws) with advice from their assistant attorney general, in order to respond to the question. If the law is not clear, they make a determination based on their knowledge and research of current commonly adopted practice. An index of previously issued interpretive or policy statements are maintained. It may also serve as a source of information for new inquiries. (The Nursing Care Quality Assurance Commission refers to these statements as advisory opinions or position statements.)

Prior to 1995 legislation, boards and commissions issued their statements with little or no input from other professions. In 1995, RCW 18.130.065 was enacted mandating the Secretary of the Department of Health (DOH) to review and coordinate all proposed interpretive statements, policy statements and declaratory orders. The intent of the review process was to assure communication among affected professions prior to the issuance of a statement regarding scope of practice.

Action:

In an effort to further enhance communication across the professions, the Nursing Care Quality Assurance Commission with staff support from the HPQA Policy Office took the lead in a series of meetings. Other meeting participants were board, commission and staff from the Medical Quality Assurance Commission, Dental Quality Assurance Commission, Board of Pharmacy, and the Board of Osteopathic Medicine and Surgery. These are the regulatory authorities most often involved in overlapping scope of practice issues. The group met four times from January through June 2001.

Result:

The work group developed a purpose statement, “To optimize communication between and among health professions quality assurance (HPQA) regulatory authorities to address potential areas of conflict prior to final statements being issued.” They also created a decision tree that could be used by boards, commissions or programs to send to practitioners to empower them to find their own answers. The decision tree was taken from a nationally accepted nursing model and it leads the individual through a series of questions to assist them in determining whether a particular act is within their scope of practice. Information was developed to accompany the decision tree that provides the inquirer with directions on how to request assistance, if they don’t find the decision tree helpful enough.

At the last meeting of the work group in June, a draft revised HPQA policy statement (A02.03) titled, *"Interpretive Statements, Policy Statements, and Declaratory Orders Proposed for Adoption or Issuance by Boards, Commissions, or Secretary Professions"* was approved. The policy includes a questionnaire be filled out by program staff particularly emphasizing the need to contact other professions and interested parties before issuing a statement. It also includes the decision tree as a resource for use by the professions.

The policy was formally adopted by HPQA on August 28, 2001. Training was provided to HPQA staff on the policy. Individual boards and commissions were notified of the new policy as well.